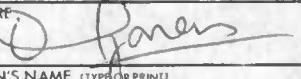


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove the carbonpaper, Pages 1 and 2, and file the original certificate in your office or in the office of the funeral director, page 3, within 72 hours after death.

IMPORTANT: If item 21 is marked as 'Yes' on Item 18 shows any injury, or other traumatic event, the medical examination will be carried out.

MEDICAL CERTIFICATION

1 - FOR STATE 309 DECATUR STREET REGISTRAR CUMBERLAND, MD 21502			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO.
1. DECEASED NAME (TYPE OR PRINT) DAVID WILLIAM ABERNATHY			2a. DATE OF DEATH NOVEMBER 14, 1983			2b. HOUR 12:10 PM
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH Feb. DAY 10, YEAR 1937	6. AGE (IN YEARS LAST BIRTHDAY) 46 yrs.		
7a. BIRTHPLACE (COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee	
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. # 4, Goldens Ave. 21502	
14. FATHER'S NAME FIRST J.		MIDDLE Ernest	LAST Abernathy	15. MOTHER'S MAIDEN NAME FIRST Zelda MIDDLE LAST Kennell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-34-2114		17. INFORMANT ADDRESS Zelda Abernathy Cumberland, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Prostate Carcinoma 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OAMAR ZAMAN, MD.		22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD 21502			22f. DATE SIGNED 11/14/83	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Nov. 16, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Cooks Mills Cem.	23d. LOCATION CITY OR TOWN Hyndman, Bedford	COUNTY Perry	STATE Pa.
24. FUNERAL DIRECTOR William G. Kight		ADDRESS Cumberland, MD	25a. DATE REC'D. BY REGISTRAR NOV 21 1983		25b. REGISTRAR'S SIGNATURE 	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be given to the funeral director. Pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										28446
										REG. NO.
1 - FOR STATE REGISTRAR		MAUREEN ELLEN ALKIRE				2a. DATE OF DEATH NOVEMBER 22, 1983				2b. HOUR 1:14 A M
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Feb. 1, DAY 1925 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION Retired				12b. KIND OF BUSINESS OR INDUSTRY Tire Industry
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN La Vale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14 Club House Rd. 21502		
14. FATHER'S NAME FIRST James F. Ogle		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST Grace Mae Buhrman				LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-14-7340		17. INFORMANT Mr. Richard L. Alkire, La Vale, Md. Husband				ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<p><u>4100</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) <u>Acute myocardial Infarction</u></p> <p>(c) <u>Coronary Artery Disease</u></p>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral stenosis, Peripheral vascular disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>Desai</u>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Halmos & DR. A.D. DESAI		22e. ADDRESS Memorial Hospital Cumberland, Maryland				23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.		23e. COUNTY STATE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-25-1983		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		ADDRESS				25a. DATE REC'D. BY REGISTRAR DEC 01 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Scarpelli</u>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
BELMONT ROBERT AMICK							<input checked="" type="checkbox"/>	XX	11-14	1983	1734M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR				
M	Cau	7-10-10	73 yrs.			11-14	1983	1734M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
West Virginia		USA				Allegany								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		Memorial Hospital					Retired Mill Dept.			ire Ind.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS			21555				
Maryland		Allegany		Oldtown			Box 12							
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST									
Robert Edgar Lee Amick					Fannie Yates Moreland									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS										
No		220-10-2248		Mrs. Dorothy May Amick, Oldtown, Md. Wife										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
												sudden		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Diabetes mellitus; hypertension; seizure disorder												years		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?							
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY)		
												M.D. Ast. Dpty MEDICAL EXAMINER		
ACTUAL SIGNATURE <i>Paul Snow</i>		DATE SIGNED 11-14-83												
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS Memorial Hospital												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		11-17-1983		Oldtown Cemetery			Oldtown		Allegany		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
James F. Scarpelli, Cumberland, Md.				NOV 21 1983			<i>D. J. G.</i>							
DHMH-17 (VR A15 ME (5))														
15M 2/80														



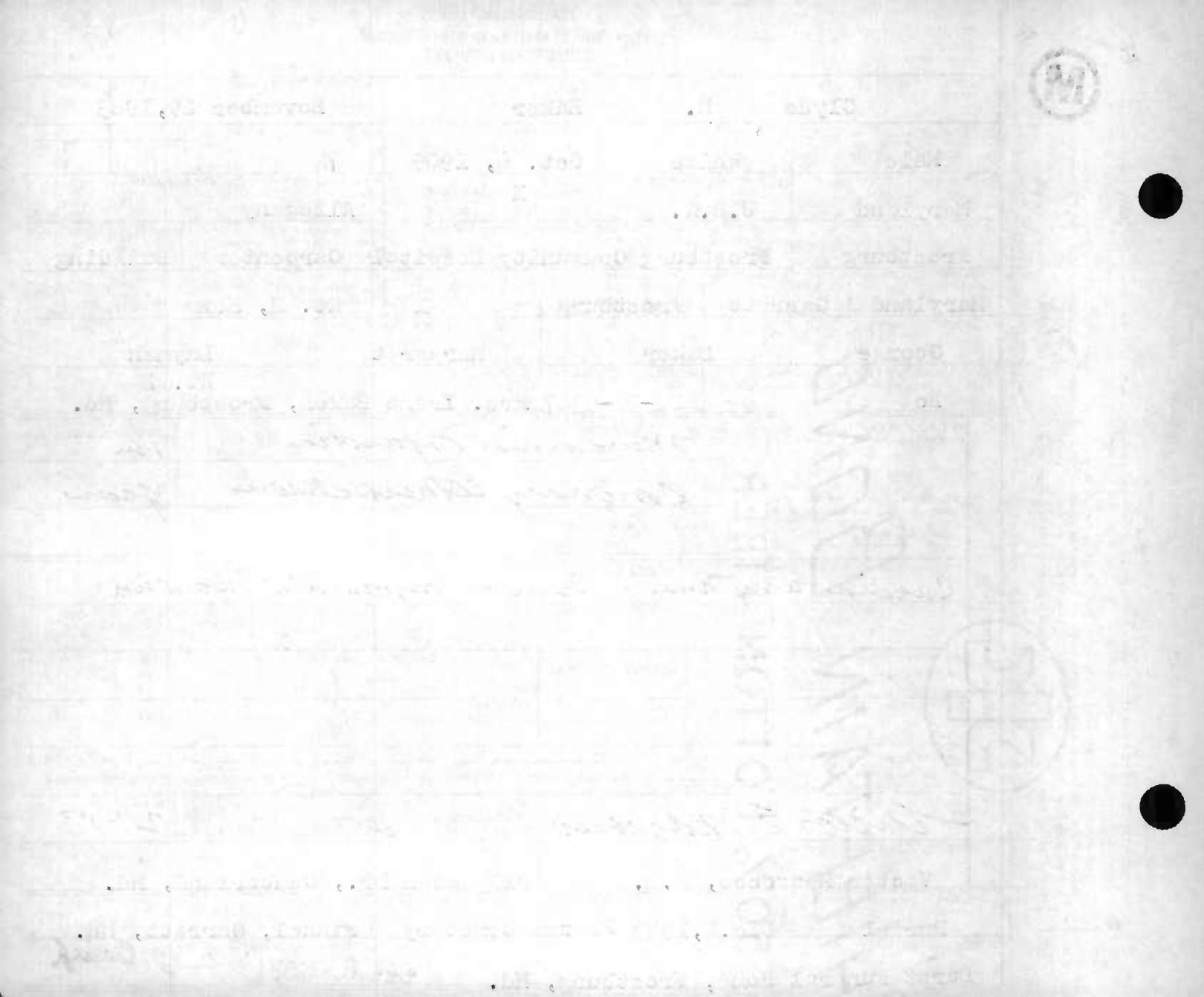
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORT PART II Item 21 is marked on Item 18 above any injury, or other traumatic event, the medical examiner must be notified.

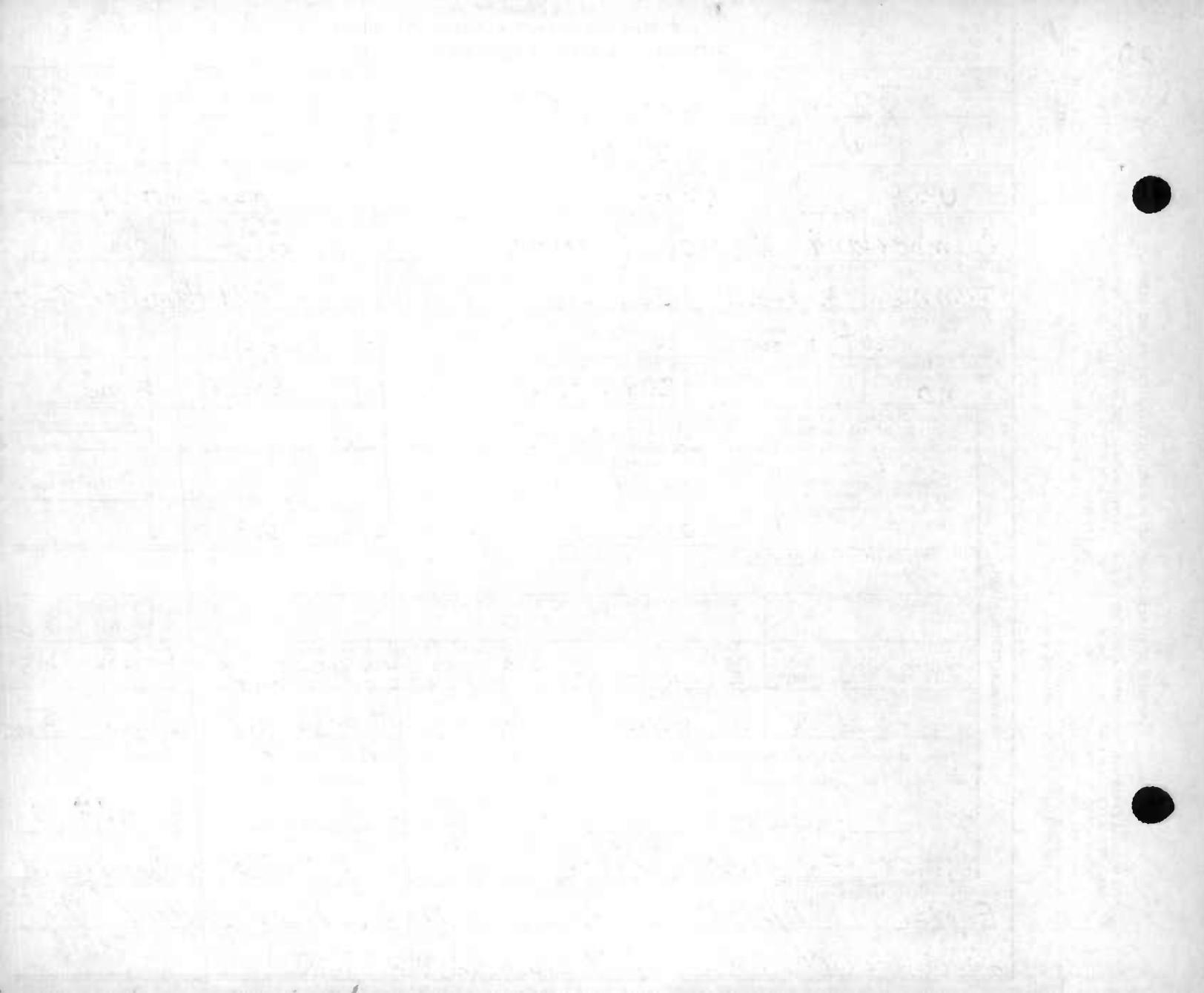
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 83 28448
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST	2a. DATE OF DEATH MONTH DAY YEAR
	Clyde E. Baker				November 29, 1983
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Male	White	Oct. 6, 1909			74 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.
Maryland	U.S.A.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Frostburg	Frostburg Community Hospital			12b. KIND OF BUSINESS OR INDUSTRY Building	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 21532
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
George Baker	Margaret Layman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS
No	214-01-6714	Mrs. Irene Baker, Frostburg, Md.			Rt. 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4100 1 hr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Atherosclerosis</i> (c) <i>Years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Cardiac arrhythmia - Previous myocardial infarction</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Victor E. Mazzocco</i> DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 912 Seton Dr., Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Dec. 2, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Finzel Cemetery		23d. LOCATION CITY OR TOWN Finzel, Garrett, Md.
24. FUNERAL DIRECTOR NAME		ADDRESS Durst Funeral Home, Frostburg, Md.		25a. DATE REC'D. BY REGISTRAR DEC 6 1983	25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>
DHMH-16 50M 1/81 (VRA 15, 4)					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 281 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												28449							
												REG. NO.							
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED								
<i>John</i>			<i>C.</i>		<i>Beagle</i>				11 17 83		YEAR 19	2b. HOUR 7:45 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 yr MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD							
M		W		2/8/1895		88 yrs.						11 17 83							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.													
U.S.A.		U.S.A.																	
10. CITY OR TOWN OF DEATH <i>Cumberland</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Druggist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>pharmacy</i>													
13a. STATE <i>Penna.</i>		13b. COUNTY <i>Bedford</i>		13c. CITY OR TOWN <i>Bedford</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>601 Hammer street</i>											
14. FATHER'S NAME FIRST <i>not Known</i>		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST <i>not Known</i>		MIDDLE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>209-10-8669</i>		17. INFORMANT ADDRESS <i>Janet. Lohr same</i>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 8839 IMMEDIATE CAUSE (a) <i>Subdural Hematoma</i> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. { DUE TO, OR AS A CONSEQUENCE OF (b) <i>Head Injury</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>accidental fall in grease pit.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 hours.</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>2 P.M. 11/17/1983</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>fell into grease pit at a garage where his car was on repair.</i>															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Car Garage</i>		21f. LOCATION STREET <i>Rt 220 North of Bedford</i>		CITY OR TOWN <i>Bedford</i>		COUNTY <i>Bedford</i>		STATE <i>Penna</i>									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		ond in my opinion															
ACTUAL SIGNATURE <i>Francisco Reyes</i>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED <i>11/17/83</i>													
EXAMINER'S NAME (TYPE OR PRINT) <i>Francisco Reyes</i>		ADDRESS <i>900 Seton Drive Cumberland</i>																	
23a. BURIAL, CREMATION, REMOVAL (CITY) <i>Burial</i>		23b. DATE <i>11/20/83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Bedford Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Bedford</i>		COUNTY <i>Bedford</i>		STATE <i>Penns</i>									
24. FUNERAL DIRECTOR NAME <i>Louis Reisel</i>		ADDRESS <i>330 E. Pitt St., Bedford, PA</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 23 1983</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Canfield</i>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR CUMBERLAND, MD 21502			SILCOX/MERRITT FUNERAL HOME 404 DECATUR STREET			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE			CERTIFICATE OF DEATH			REG. NO. 28450					
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
JOSEPH ALPHONSE BENDER						NOVEMBER 11, 1983			10:30AM								
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Jan 24 1914			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.								
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Spinning Dept			12b. KIND OF BUSINESS OR INDUSTRY Textile								
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 715 Frederick Street 21502					
14. FATHER'S NAME FIRST MIDDLE LAST Alpheus Bender						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-10-4114			17. INFORMANT Mrs. Grace Bender			ADDRESS 715 Frederick St Cumberland, Md 21502								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Transitional Cell Ca. of the Bladder.</i>						DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.						DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>COP.D. Ca. of the Rectum with Perirectal Closity.</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE <i>Clarence Vincent M.D.</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) CLARENCE VINCENT, MD			22f. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Nov 12, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Rosedale Crematory			23d. LOCATION CITY OR TOWN Martinsburg Berkeley W. Va								
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service, Cumberland, Md			ADDRESS 404 Decatur St			25a. DATE REC'D. BY REGISTRAR NOV 15 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Carrick</i>								

ANCIENT

CARIBBEAN

THE

1916

ARCHITECTURE

1916-201

YESTERDAY

SEARCHED INDEXED

SEARCHED INDEXED SERIALIZED FILED (983)

800-5 SOUTH DRIVE, GREENWICH, CONNECTICUT

CLARENCE VANDERBILT

SEARCHED INDEXED SERIALIZED FILED
JULY 19 1964

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 2 8 4 5 1						
										REG. NO.						
1 - FOR STATE REGISTRAR			FIRST			MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			PHYLLIS			ELLEN		BLAMER		November 22, 1983					9:50 A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 MONTHS			
Female			White			March 1, 1924			59		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.					
Pa.			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland			Memorial Hosp. & Medical Center, Inc.			Homemaker			--							
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
W.Va.			Mineral			Keyser			Rt 4 Box 96A Keyser, W.Va.							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
First Lance			Middle Saunders Last			No			233-34-5829			Charles E. Blamer, Jr.				
												ADDRESS				
												Rt 4 Box 96A Keyser, W.Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of the lung</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)																
DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Pneumonia, congestive heart failure, Diabetes mellitus.</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 16, 1983</i> , to <i>Nov. 22, 1983</i> , that (I) (we) last saw the deceased alive on <i>Nov. 22, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.										22c. DATE SIGNED <i>11/22/83</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
Dr. Susan Schwartz			Frostburg Plaza, Frostburg, MD 21532													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		Mineral		W.VA			
Burial			25 Nov 83			Queens Point			Keyser							
24. FUNERAL DIRECTOR NAME			A. Craig Rotruck			KEYSER, W.VA.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
									NOV 28 1983		<i>A. Craig Rotruck</i>					

• 16 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 payable
returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT:

MEDICAL CERTIFICATION

1 - FOR STATE 202 GREEN STREET REGISTRAR
GEORGE UPCHURCH FUNERAL HOME
CUMBERLAND, MD 21502
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST PAULINE	MIDDLE ALBERTA	LAST BLUME	2a. DATE OF DEATH NOVEMBER 18, 1983	MONTH YEAR	2b. HOUR 8:00 A.M.
3. SEX White	4. RACE Female	5. DATE OF BIRTH MONTH March	DAY 16	YEAR 1905	6. AGE (IN YEARS LAST BIRTHDAY) 78	YEARS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY	MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.-21502	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 525 Henderson Avenue 21502		
14. FATHER'S NAME FIRST James	MIDDLE G.	LAST Brant	15. MOTHER'S MAIDEN NAME FIRST Amelia	MIDDLE --	LAST Filsinger	ADDRESS 201 Burbank Road Wilmington, N.C.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b. SOCIAL SECURITY NO. - 213-74-2894	17. INFORMANT John K. Pfeiffer	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART II OR PART 2) saw the deceased drive on NOV. 17 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCT. 10 19 83, to NOV. 18 19 83, that (I) (we) last saw the deceased drive on NOV. 17 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Kenneth Zeinkiewicz, MD</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/18/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH ZEINKIEWICZ, MD.	22e. ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/21/83	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION CITY OR TOWN Cumberland-Allegany Co. - M	STATE Md.		
24. FUNERAL DIRECTOR NAME George Upchurch Funeral Home, P.A.	ADDRESS 202 Greene Street-Cumberland, Maryland 21502	25a. DATE REC'D. BY REGISTRAR DEC 01 1983	25b. REGISTRAR'S SIGNATURE <i>George Upchurch</i>			

APPENDIX A



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10A, WHICH IS TO BE FILLED OUT BY THE MEDICAL EXAMINER. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, 3 AND 4 ARE TO BE FILED WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												28453			
												REG. NO.			
1. FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. KNOWN OF DEATH ESTI- MATED		2b. HOUR	
LLOYD			C.			BOHN						<input checked="" type="checkbox"/>		MONTH DAY YEAR	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		11-6 19 83	1644
M		Cau		8-8-23		60 yrs						11-6 19 83		1644	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH									
Pa.			USA			Allegany									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cumberland			Memorial Hospital						Salesman			Auto			
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			MD. 999999			
Penn			Bedford			Manns Choice			R D 1, Box 108/ 15550						
14. FATHER'S NAME FIRST			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST						
Harvey A. Bohn						Mary Hurley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
no			177 24 8109			Evelyn Bohn, Bx 108, R D 1, Manns Choice,			Pa. 15550						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
4100 IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last</u> .															
(b) <u>Acute myocardial infarction</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Paul Snow</u>															
TITLE (SPECIFY) M.D. <u>Ast. Dpty</u> MEDICAL EXAMINER															
DATE SIGNED <u>11-6-83</u>															
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			Memorial Hospital									
23a. BURIAL CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE			
Burial			11/10/83			Milligan's Cove Cem.			Harrison Twp., Bedford Cty, Pa.						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Harvey H. Zeigler			Clarence St., Hyndman, Pa.			11-14-83			Paul J. Cawie						

Ward 200 A 1.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time of death. The physician or attending physician must retain a copy of the death certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked **Yes**, if there was any injury, or other traumatic event, the medical examiner must be notified and the cause of death must be determined before the death certificate can be issued.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28454

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MELVIN GLENN BOHRER						NOVEMBER 7, 1983			7:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
MALE		White		MONTH	DAY	YEAR	64			MONTHS	DAYS
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 14 HOURS	
W.V.		USA					Allegany			MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND		MEMORIAL HOSPITAL		Driver			Trucking				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 639 Elm St. 21502		
14. FATHER'S NAME FIRST G. MIDDLE W. LAST Bohrer						15. MOTHER'S MAIDEN NAME Minnie			LAST Raigner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. Yes 38-39 233-18-7374			17. INFORMANT ADDRESS			Cumberland, Md. 21502		
						Virginia Coffman Bohrer, 639 Elm St.					
18. CAUSE OF DEATH (Enter only one cause per line following b), and c.) PART I. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) 4360 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.						Today 10 days					
DUE TO, OR AS A CONSEQUENCE OF (b) Coagulopathy vascular occlusive disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Deceased anticoagulated during											
19a. DATE OF OPERATION 10 Sept. 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Emergency				19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Died 1981, to 1983, then (we) lost					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 83</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>9 Nov. 83</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Frederick Miltenberger		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/10/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. FREDERICK MILTENBERGER						22e. ADDRESS 122 South Centre Street Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 11/10/83		23c. NAME OF CEMETERY OR CREMATORIAL Woodrow Cemetery			23d. LOCATION CITY OR TOWN Paw Paw, Morgan, WV COUNTY STATE				
24. FUNERAL DIRECTOR NAME Helsley-Johnson F.H., 306 Union St. NOV 16 1983						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John & Coyle					

SOCIAL INTEGRATION

Spinal fluid ~~Specimen~~ ~~Specimen~~ ~~Specimen~~ ~~Specimen~~ ~~Specimen~~ ~~Specimen~~

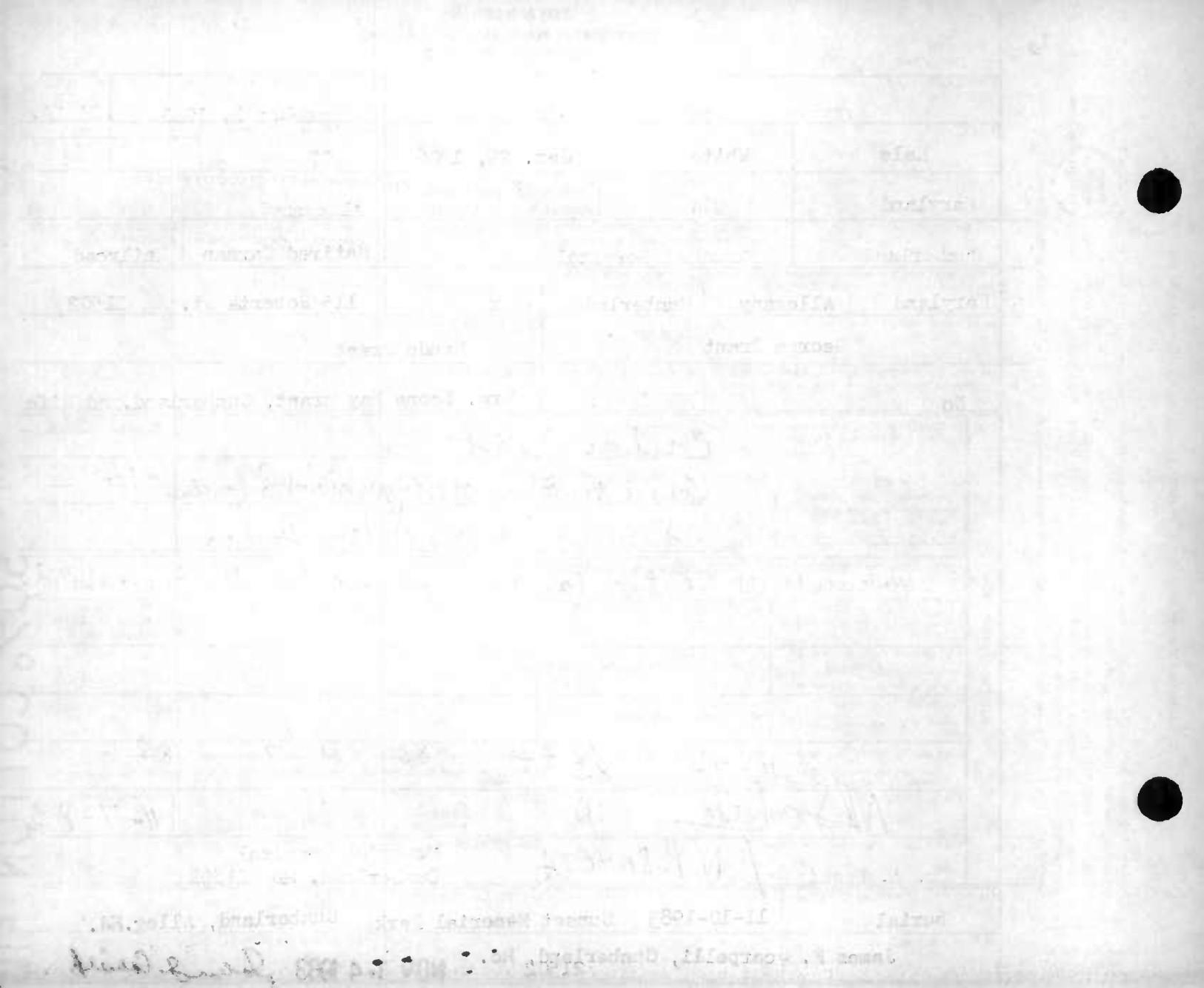
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8328455
1 - STATE REGISTRAR					
I. DECEASED NAME (TYPE OR PRINT)		FIRST GEORGE	MIDDLE WILLIAM	LAST BRANT	2a. DATE OF DEATH November 7, 1983
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1906	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Carman
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 115 Roberts St. 21502
14. FATHER'S NAME FIRST George		MIDDLE Brant	LAST	15. MOTHER'S MAIDEN NAME FIRST Maude	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 705-10-7288		17. INFORMANT Mrs. Leona May Brant, Cumberland, Md Wife	ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Anterior Wall Myocardial Infarction</u> 14 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Coronary Artery Disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Anterior wall ventricular Aneurysm, Ventricular Irritability</u>					
19a. DATE OF OPERATION 9/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>10-23-</u> , 19 <u>83</u> , to <u>11-7-</u> , 19 <u>83</u> , that (I) (we) last saw the deceased living on <u>11-7-</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (or did not) view the body after death.					
22b. SIGNATURE <u>N. P. Sahota MD.</u>		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22c. DATE SIGNED <u>11-7-83</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Desai		22e. ADDRESS <u>N. P. SAHOTA</u>	Memorial Hospital Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 11-10-1983	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION CITY OR TOWN Cumberland, Alleg. Md.	COUNTY STATE
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502					
25a. DATE REC'D. BY REGISTRAR NOV. 14 1983					
25b. REGISTRAR'S SIGNATURE <u>John J. Casper</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR			111 CHURCH STREET WESTERNPORT, MD 21562			DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			28 156		
									REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			WILHELMINA BRENNAN			2a. DATE OF DEATH NOVEMBER 28, 1983			2b. HOUR 4:30A M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 5 2 1889			6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.		
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION Housework			12b. KIND OF BUSINESS OR INDUSTRY Domestic		
13a. STATE Maryland			13b. COUNTY Allegany			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Box 195 21521		
14. FATHER'S NAME FIRST Edward			MIDDLE Brennan			15. MOTHER'S MAIDEN NAME Isabella			LAST Brooks		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-16-9166			17. INFORMANT Mary Brodie			ADDRESS Barton, Md 21521		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days		
<i>4360</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized atherosclerosis</i>						years.		
			DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive Heart Failure, atrial fibrillation, urinary tract infection</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 22 1983</i> , to <i>Nov 28 1983</i> , that (I) (we) last saw the deceased alive on <i>Nov. 27 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Henry J. Devlin</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 11-28-83		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS DEVLIN, M.D.						22f. ADDRESS 55 JACKSON STREET, LONACONING, MD 21539					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/1/83			23c. NAME OF CEMETERY OR CREMATORIUM St. Gabriels Cemetery			23d. LOCATION Barton Allegany County Maryland		
24. FUNERAL DIRECTOR NAME <i>John J. Boals</i>			ADDRESS Boals Funeral Service Westernport Md 21562			25a. DATE REC'D. BY REGISTRAR DEC 5 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>		



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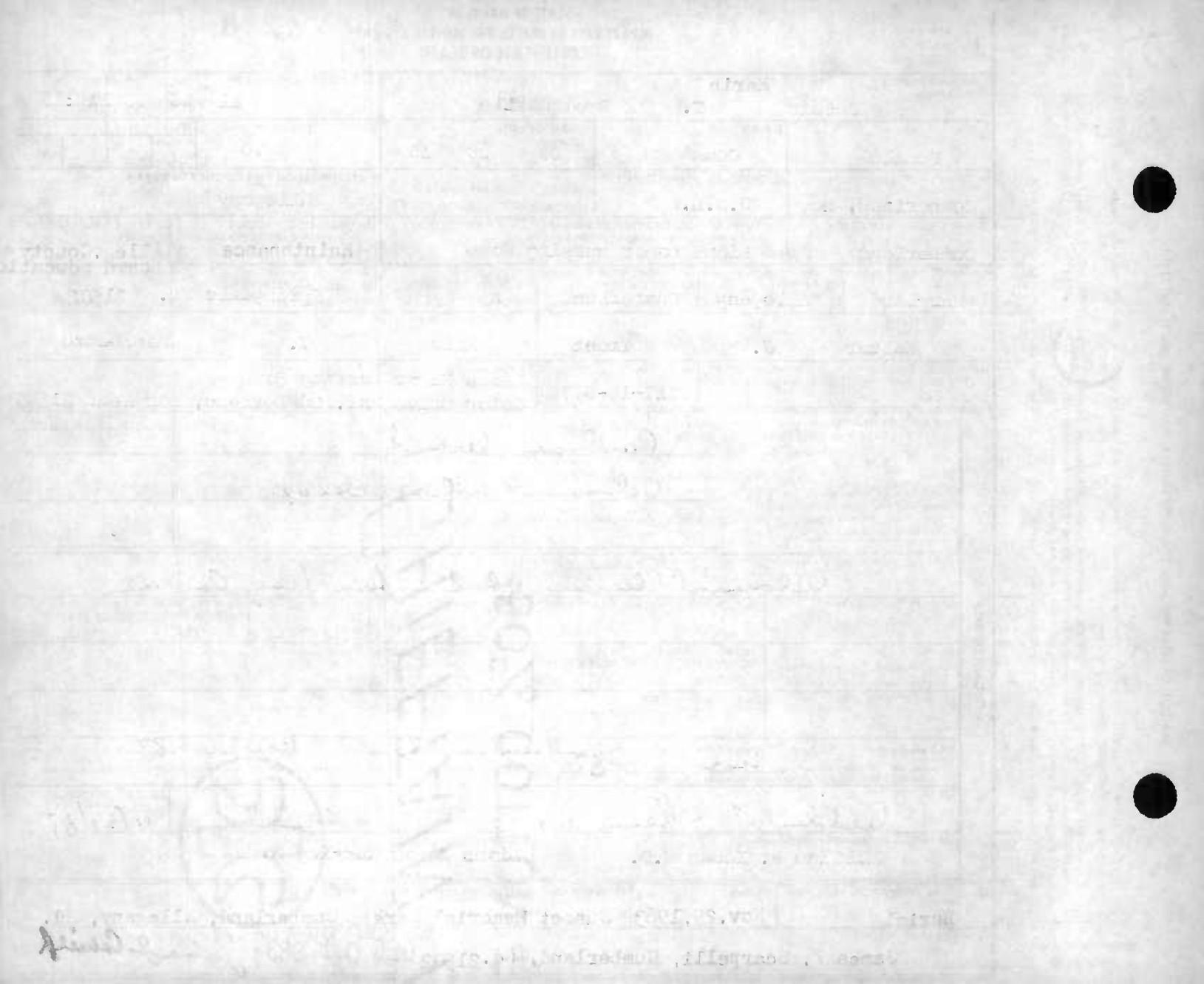
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28451	
1 - STATE REGISTRAR			2a. DATE OF DEATH 11 26 83									2b. HOUR 10:15 A.M.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Marie			MIDDLE F.			LAST Brotemarkle					
3. SEX Female		4. RACE Caus			5. DATE OF BIRTH MONTH 03 DAY 28 YEAR 13			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cumberland, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home			12a. USUAL OCCUPATION Maintenance			12b. KIND OF BUSINESS OR INDUSTRY Alleg. County Board Education					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS 109 Springdale St. 21502					
14. FATHER'S NAME FIRST Walter		MIDDLE J.		LAST Trout		15. MOTHER'S MAIDEN NAME FIRST Alice		MIDDLE V.			LAST Robinette		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-5476			17. INFORMANT Lions Manor Nursing Home		ADDRESS Seton Drive Ext. Cumberland, Maryland 21502						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerous Arteriosclerosis		DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Arteriosclerous Arteriosclerosis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Sene</u> , 19 83, to <u>Kore</u> , 19 83, that (I) (we) last saw the deceased alive on <u>Kore</u> , 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Willie P. James</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/27/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. James M.D.		22e. ADDRESS Lions Manor Nursing Home											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 29, 1983			23c. NAME OF CEMETERY OR CREMATORIALY Sunset Memorial Park			23d. LOCATION CITY OR TOWN Cumberland			COUNTY Allegany, Md. STATE		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR DEC 01 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>								
DHMH - 16 50M 4/82 (VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										28458				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
WADE SMITH BROTEMARKLE						NOVEMBER 1, 1983						1:55		
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White		MONTH DAY YEAR July 20, 1904	79			MONTHS	YEARS	MONTHS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION Retired Maintenance-Board Ed			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 109 Springdale St. 21502				
14. FATHER'S NAME FIRST Andrew J. Brotemarkle			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Alla Wilson			MIDDLE	LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-07-3319		17. INFORMANT Mr. James Farris, Cumberland, Md.			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory arrest</i> <i>4960</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Selene COPD</i> (c) <i>DUE TO, OR AS A CONSEQUENCE OF</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Bilateral pneumonia, coronary art. disease, malnutrition</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>10-01-1983</i> to <i>11-1-1983</i> , to <i>11-1-1983</i> , that (I) (we) last saw the deceased alive on <i>10-01-1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <i>11/02/83</i>				
22b. SIGNATURE <i>Sheila Neale</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. NATHAN			MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-3-1983		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.			23e. COUNTY STATE				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.			25a. DATE REC'D. BY REGISTRAR NOV 7 1983			25b. REGISTRAR'S SIGNATURE <i>John G. Comer</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

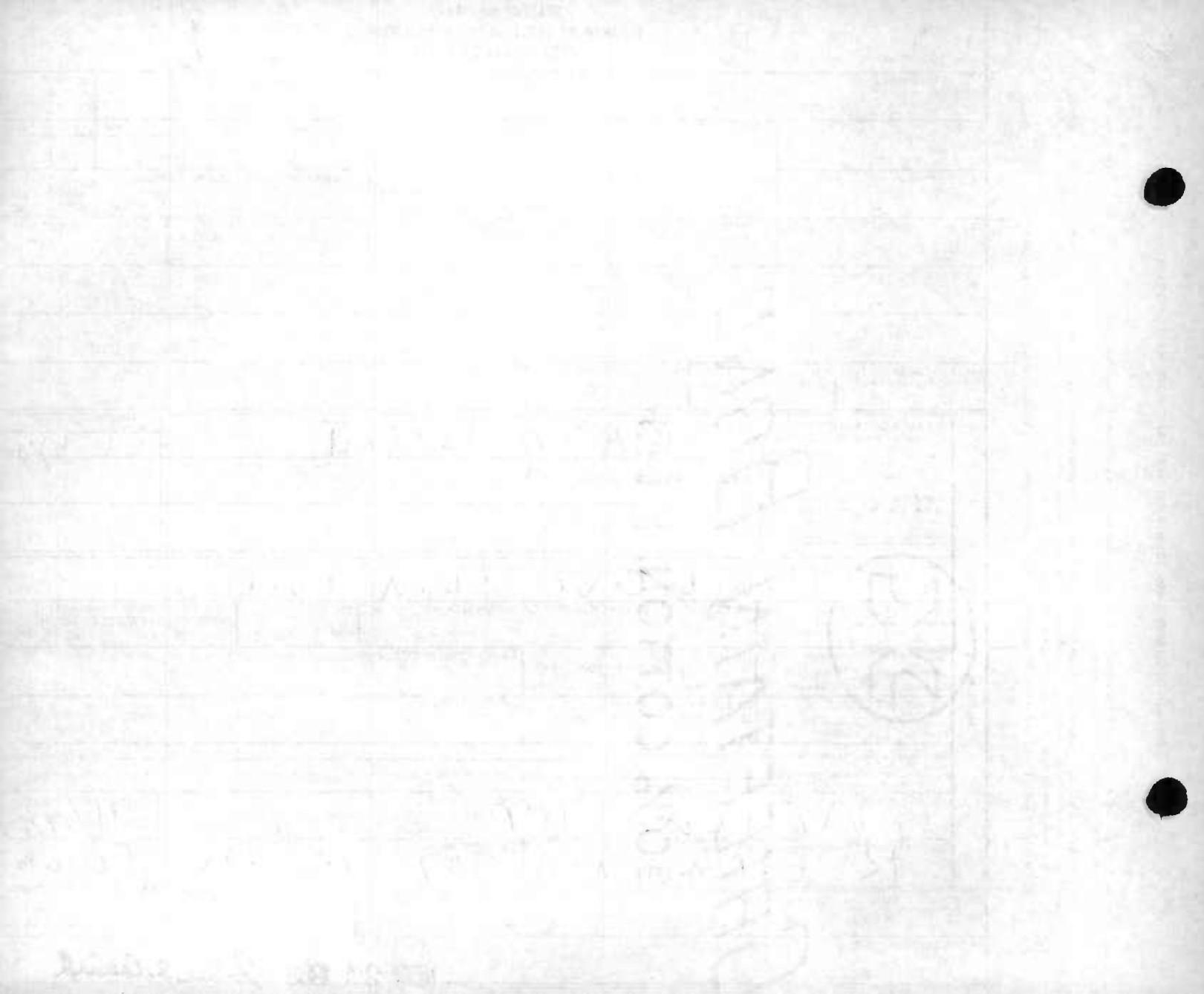
HAFER FUNERAL HOME 58 FROST ST. FROSTBURG, MD 21532			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO. 28459	
1. FOR STATE REGISTRAR							
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	
LAWRENCE JAMES CAREY						NOVEMBER 28, 1983	
3. SEX			4. RACE	5. DATE OF BIRTH		2b. HOUR	
Male			White	Month August 24 1919		10:50 P.M.	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
Maryland			USA				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			9. BALTIMORE CITY OR COUNTY OF DEATH	
Cumberland			SACRED HEART HOSPITAL			ALLEGANY COUNTY, MD.	
13a. STATE Maryland			13c. COUNTY Garrett	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2, Box 528 / 21502 ZIP CODE	
14. FATHER'S NAME John Lawrence Carey			15. MOTHER'S MAIDEN NAME Rose Ann Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II	17. INFORMANT Vivian Carey - same as above			12b. KIND OF BUSINESS OR INDUSTRY Trucking
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1509			DUE TO OR AS A CONSEQUENCE OF (b) Metastasis to Liver & Lung			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Nov 28, 1983		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <u>Nov 28, 1983</u> to <u>Nov 28, 1983</u> , that (I) (we) last saw the deceased alive on <u>Nov 28, 1983</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <i>Chang Oh, M.D.</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED Nov 30, 1983	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) CHANG OH, M.D.		22g. ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-01-83		23c. NAME OF CEMETERY OR CREMATORIAL Blocher Cemetery		23d. LOCATION CITY OR TOWN Near Frostburg, Garrett County MD	
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS Frostburg, MD		25a. DATE REC'D. BY REGISTRAR NOV 30 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Hafer, Jr.</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28460									
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
			Ellen				NMI				Carman		Nov. 17, 1983					10:01 A.M.			
3. SEX			F'Emale				4. RACE		White		5. DATE OF BIRTH		MONTH Nov.	DAY 29,	YEAR 1895	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
																87	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			W.Va.				7b. CITIZEN OF WHAT COUNTRY?		U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.						
10. CITY OR TOWN OF DEATH			LaVale, Md.				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Rt. #1 Box 112H		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Housewife				12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE			Md.		13b. COUNTY		Allegany		13c. CITY OR TOWN		LaVale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		Rt. #1 Box 112H 21502				
14. FATHER'S NAME			Elias		MIDDLE		Keenan		15. MOTHER'S MAIDEN NAME		Martha		FIRST		MIDDLE		LAST		Glover		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			No		16b. SOCIAL SECURITY NO.		232-09-8058-D		17. INFORMANT		John L. Carman		ADDRESS		Rt. #1 Box 112H						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA 9 Belmont												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b)																			
		DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															Congestive Heart Failure						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																					
22b. SIGNATURE R. Espina, MD			22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 11/17/83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Espina, MD			22e. ADDRESS 907 Seton Dr. Cumberland, Md.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 19, 1983				23c. NAME OF CEMETERY OR CREMATORIAL Harmony Baptist Cemt.		23d. LOCATION CITY OR TOWN Burton		COUNTY Wetzel		STATE W.Va.								
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Ser.			ADDRESS 404 Decatur St. Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR Nov. 21, 1983		25b. REGISTRAR'S SIGNATURE John J. Cawieh												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached from the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medicolegal form must be completed.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 3 2 8 4 6 1

1. DECEASED NAME (TYPE OR PRINT)			FIRST CECIL	MIDDLE ELMER	LAST CLIFTON	2a. DATE OF DEATH NOVEMBER 26, 1983	MONTH DAY YEAR	2b. HOUR 9:45 P M			
3. SEX MALE		4. RACE Caus		5. DATE OF BIRTH MONTH 7 DAY 6 YEAR 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL	
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Mt. Savage		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 123, Route 1		12b. KIND OF BUSINESS OR INDUSTRY Tire Manuf. 215-45	
14. FATHER'S NAME FIRST Walter		MIDDLE Clifton		15. MOTHER'S MAIDEN NAME Ida							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Ruth Clifton, Bx 123, Route 1, Mt. Savage		ADDRESS Md. 21545					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ankle Fracture</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Obstructive Lung Disease</i> (c) <i>Congestive Cardiac Failure</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) here		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 26</i> , 1983, to <i>Nov 26</i> , 1983, that (I) (we) lost saw the deceased alive on <i>Nov 26</i> , 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William P. James MD</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <i>11/27/83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William P. James		22e. ADDRESS 441 N. Centre Street Cumberland, Maryland 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/30/83		23c. NAME OF CEMETERY OR CREMATORIAL Rest Lawn Mem. Park		23d. LOCATION CITY OR TOWN LaVale COUNTY Allegany STATE Md.					
24. BURIAL DIRECTOR <i>Harvey H. Zeigler</i>		ADDRESS Hyndman, Pa. 15545				25a. DATE REC'D. BY REGISTRAR DEC 01 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>			

BP _____

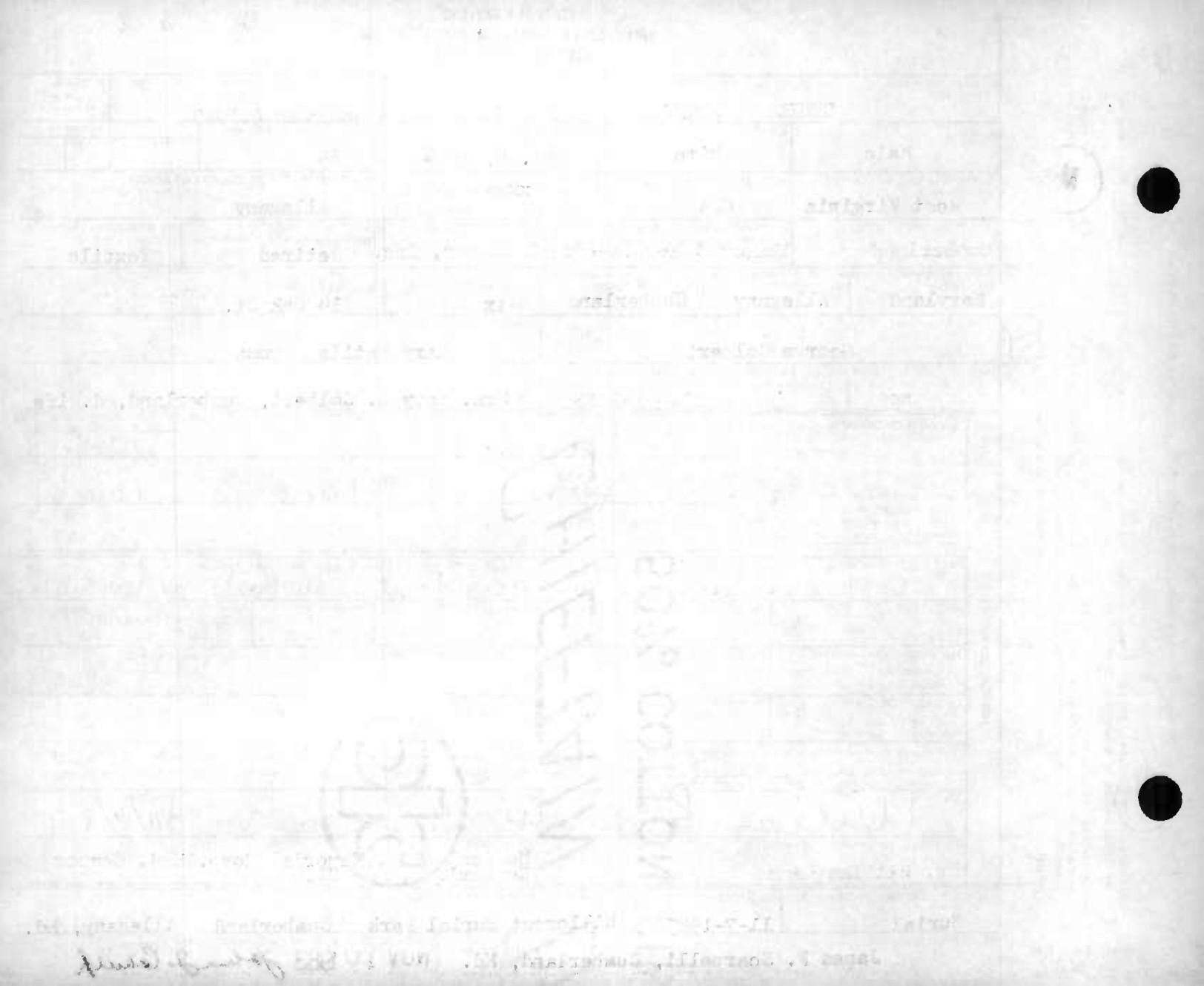


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 28462	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR 8:15 AM		
CECIL CORELLA COLBERT						November 4, 1983					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1894			6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.			IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp.&Medical Center, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Textile				
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 21502	
14. FATHER'S NAME FIRST		MIDDLE George Colbert		LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Matila Gross			ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-07-2653		17. INFORMANT Mrs. Mary G. Colbert, Cumberland, Md. Wife						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure } DUE TO, OR AS A CONSEQUENCE OF (c) } DUE TO, OR AS A CONSEQUENCE OF 1 week.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Left cerebrovascular accident with territorial hemorrhage											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10-29, 1983, to 11-4, 1983, that (I) (we) last saw the deceased alive on 11-3, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.											
22b. SIGNATURE William Lamm MD		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/4/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Lamm		22e. ADDRESS Medical Bldg. Memorial Hosp.&Med. Center Cumberland, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-7-1983		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park			23d. LOCATION CITY OR TOWN Cumberland COUNTY STATE Allegany, Md.				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR 11UV 10 1983		25b. REGISTRAR'S SIGNATURE James F. Scarpelli							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be detached from the hospital or attending physician's papers. Pages 1 and 2 should be filed within 72 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the hospital or attending physician's papers. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										28 . 6 3			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ANNA			LEE		DAY	November 23, 1983						1:10 P.M.	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			White		Feb. 14, 1919		64			MONTHS	YRS.	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
West Virginia			USA				Allegany						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland			Memorial Hospital & Medical Center		Housewife			In Own Home					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			99999		
13a. STATE West Va.			13c. COUNTY Mineral		13d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Route 2					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Evan Hiett						Annie Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				Daughters	
no			215-18-8199		Ms. Vida Snyder & Ms. Carleen Powell								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5715 LIVER FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) CIRRHOSIS													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) HEPATIC COMA, GT BLEEDING													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/17/83 to 11/23/83, to 11/23/83, that (we) last saw the deceased alive on 11/23/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE Dr. S. Nathan			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/23/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Medical Bldg., Memorial Hosp. & Med. Cntr., Inc Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial			11-26-1983		Restlwan Mem. Gardens			LaVale, Allegany, Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
James F. Scarpelli, Cumberland, Md. 21502						DEC 01 1983			Lung C. Smith				

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SOCIS, 64, Ann Arbor, Michigan, U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8328464		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH NOVEMBER 25, 1983							2b. HOUR 7:35 PM		
1. DECEASED NAME (TYPE OR PRINT)			FIRST PIETRO D. MIDDLE DELLORCO LAST			2c. DATE OF DEATH NOVEMBER 25, 1983			2d. HOUR 7:35 PM			
3. SEX MALE			4. RACE Italian			5. DATE OF BIRTH MONTH 4 DAY 14 YEAR 1906			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.			
7a. BIRTHPLACE COUNTRY Italy			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer			12b. KIND OF BUSINESS OR INDUSTRY Paper			
13a. STATE Wv.			13b. COUNTY Mineral			13c. CITY OR TOWN Piedmont			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 11 Green St. 99999						13f. STREET ADDRESS 11 Green St. 99999						
14. FATHER'S NAME FIRST Francisco MIDDLE Dell MIDDLE Dell'Orco LAST			15. MOTHER'S MAIDEN NAME FIRST Gracia MIDDLE D'Ossisi LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YEAR OF UNKNOWN) Yes WW II			16b. SOCIAL SECURITY NO. 217-05-0226			17. INFORMANT Felicia C. Dell'Orco			ADDRESS Green St. Piedmont, Wv.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Respiratory Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) Severe COPD												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Acute bronchitis												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11/25/83 to 11/25/83, that (we) last saw the deceased alive on 11/25/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE DR. S. NATHAN for Dr. Raver			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/26/83			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial			23b. DATE 11-28-83			23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cemetery			23d. LOCATION CITY OR TOWN Westernport, Alleg. COUNTY Md. STATE			
24. FUNERAL DIRECTOR NAME William H. Fredlock			31 Jones St			35a. DATE REC'D. BY REGISTRAR DEC 7 1983			35b. REGISTRAR'S SIGNATURE Janice			
ADDRESS Piedmont, Wv.												

— 1 —

174

to avoid it

• Options

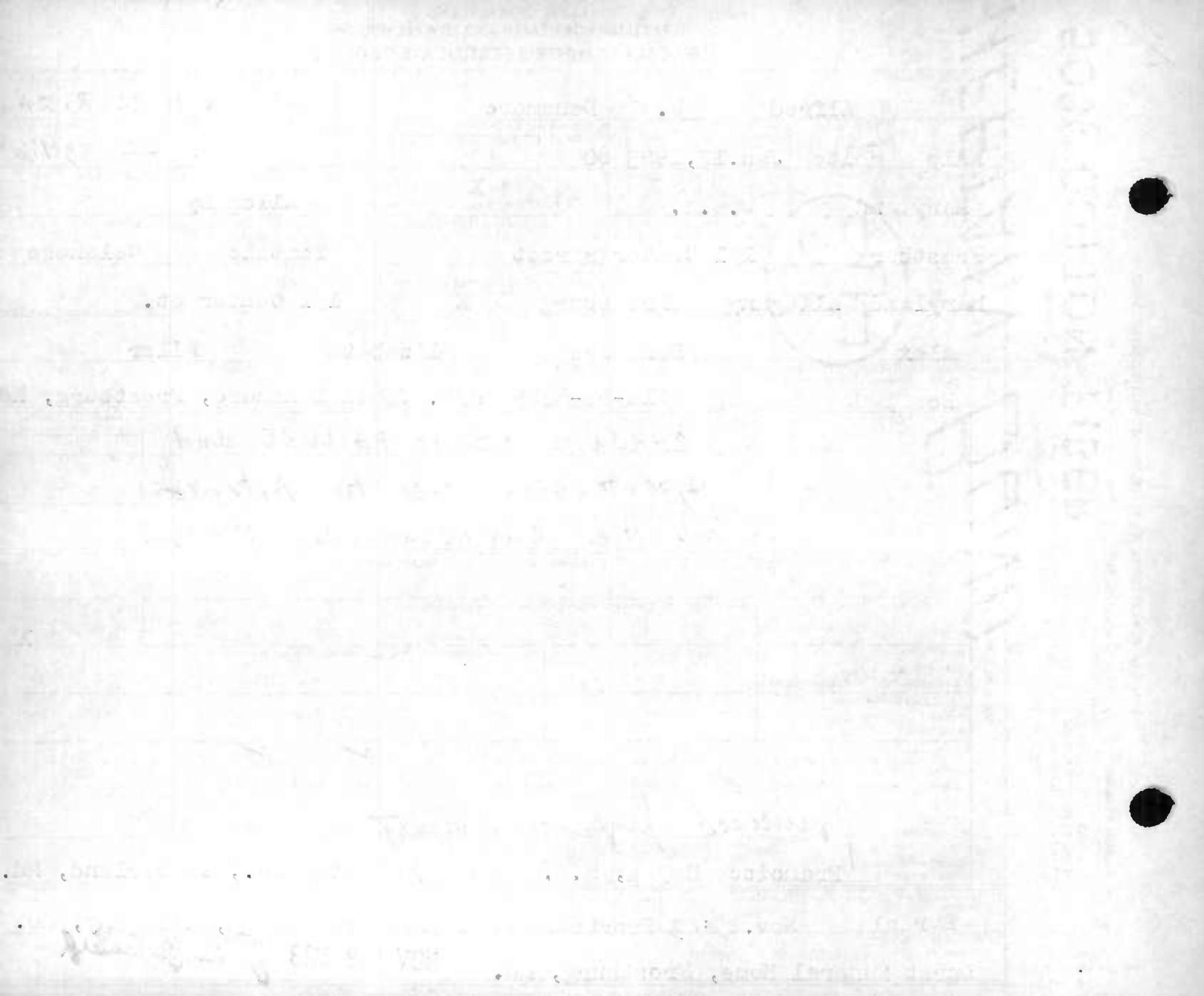
321091

cont'd

• 30018

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 8 4 6 5	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
Alfred W. Densmore						<input checked="" type="checkbox"/> 11 22 1983			11	22	1983	21h M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
Male	White	Jan. 12, 1903	80			<input checked="" type="checkbox"/> 11 22 1983			11	22	1983	9 30 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frostburg			151 Center Street			Textile			Celanese				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS				
Maryland			Allegany			Frostburg			151 Center St.				
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST				
Alex						Elizabeth			Filer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			216-09-4405			Mrs. Viola Densmore, Frostburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE and 4049 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension due to Arterios													
DUE TO, OR AS A CONSEQUENCE OF (c) sclerotic cardiovascular Disease.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												DATE SIGNED	
ACTUAL SIGNATURE		TITLE (SPECIFY) Francisco Reyes M.D. Deputy MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 900 Seton Dr., Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Nov. 25 1983			23c. NAME OF CEMETERY OR CREMATORIUM Frostburg Mem. Park			23d. LOCATION CITY OR TOWN Frostburg, Allegany, Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy				
Durst Funeral Home, Frostburg, Md.													
DHMH-17 (VR A15 ME (5)) 15M 2/80													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										28465			
										REG. NO.			
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
		Clarence			Doolittle			11/3/83			3:30 P.M.		
3. SEX		4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White			Oct 6 1897			86 yrs					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
West Virginia		U.S.A.						Allegany MD.			Army		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Cumberland		Cumberland and Nursing and Convalescent Center						Retired Veteran			Army		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME	
Maryland		Allegany		Cumberland					527 Fayette Street 21502			FIRST MIDDLE LAST	
												Sarah Price	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes		WWI&WWII		214-07-0495			Mrs. Dorothy Collins Fairfax Station, Va 22039			Carcinoma of Prostate with wide-spread secondaries.		4 months.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)								
1850													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 10.													
Metabolic Encephalopathy. Old Age.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 7-4-1983 to 11-3-1983, that (I) (we) last saw the deceased alive on 10-3-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
N.P. SAHETA								11-3-1983					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
N.P. SAHETA		MEMORIAL Hosp., Cumberland Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE			
Burial		Nov 7, 1983		Rose Hill Cemetery			Cumberland Allegany Maryland						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Silcox-Merritt Funeral Service. Cumberland Md		404 decatur St			NOV 9 1983			John C. Conner					

1000000

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Wind Energy Event

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other nonaccidental event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 28461						
1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM	MIDDLE EDWARD	LAST EICHNER	2a. DATE OF DEATH November 14, 1983	MONTH NOV	DAY 14	YEAR 1983	2b. HOUR 2:00 P.M.		
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH Aug DAY 13 YEAR 1900			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS		IF UNDER 24 HRS HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD						
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Tax Assessor		12b. KIND OF BUSINESS OR INDUSTRY Allegany co		21502			
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1100 Frederick Street				
14. FATHER'S NAME FIRST J		MIDDLE Charles	LAST Eichner	15. MOTHER'S MAIDEN NAME FIRST Sarah			MIDDLE	LAST Bray				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-07-2928			17. INFORMANT Thelma E. Eichner		ADDRESS 1100 Frederick St					
18. CAUSE OF DEATH (Enter only one cause per line for Part I and Part II) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF, <i>Cardiovascular Arrest</i> (c) DUE TO, OR AS A CONSEQUENCE OF, <i>CHF, ASCVD</i> , <i>CVA</i> , <i>Chronic UTI</i>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FAIR, ETC.) Nov. 7, 1983			21f. LOCATION STREET Nov. 14, 1983		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) or (we) did not remove from the deceased alive on Nov. 14, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE Dr. Terry Williams					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-14-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams					22e. ADDRESS Medical Bldg., Memorial Hosp. & Med. Center, Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 17, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION CITY OR TOWN Cumberland Allegany Maryland		COUNTY STATE			
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service		ADDRESS 404 Decatur St			25a. DATE REC'D. BY REGISTRAR NOV 17 1983		25b. REGISTRAR'S SIGNATURE <i>Silcox & Merritt</i>					
BP _____												
DHMH - 16 50M 4/82 (VRA 15, 4)												

June 2nd 1971

1971

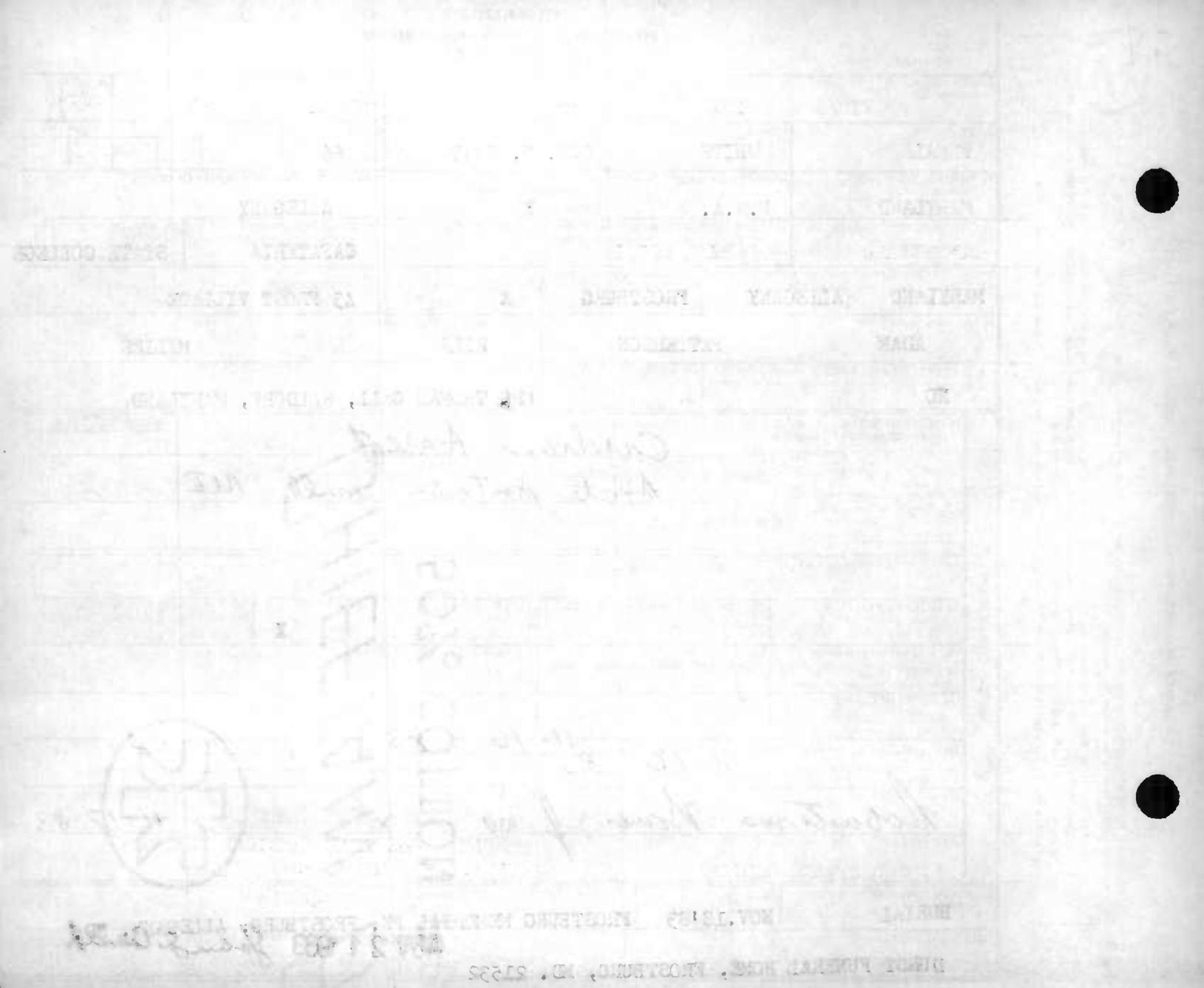
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified in place.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	2	8	4	6	8				
										REG. NO.										
1 - FOR STATE REGISTRAR			FIRST VIOLA			MIDDLE MAE			LAST GALL			2d. DATE OF DEATH NOVEMBER 16, 1983			2b. HOUR 3:45 A.M.					
1. DECEASED NAME (TYPE OR PRINT)																				
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH OCT. 7, 1917			6. AGE (IN YEARS LAST BIRTHDAY) 66			IF UNDER 1 YEAR YRS.			IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY											
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAFATERIA			12b. KIND OF BUSINESS OR INDUSTRY STATE COLLEGE											
13a. STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 43 FROST VILLAGE 21532								
14. FATHER'S NAME ADAM			MIDDLE PATTERSON			15. MOTHER'S MAIDEN NAME ELLA			16. SOCIAL SECURITY NO. 218-07-9614			17. INFORMANT MR. THOMAS GALL, WALDORF, MARYLAND			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Cardiac Arrest			DUE TO, OR AS A CONSEQUENCE OF (b) Acute anterior wall MI						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)														
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-16-83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			11-16-83			11-16-83														
22b. SIGNATURE Robustiano Barrera, Jr. MD						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-17-83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBUSTIANO BARRERA						23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE NOV. 18 83			23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEMORIAL PK			23d. LOCATION CITY OR TOWN FROSTBURG			23e. COUNTY ALLEGANY		
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD. 21532						ADDRESS NOV 21 1983														



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Please type or print.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use on the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28469	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR November 27, 1983							2b. HOUR 3:30 a.m.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES	MIDDLE LESTER	LAST GARDNER							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 03 YEAR 10			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL AND MEDICAL CTR.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE		13b. COUNTY Preston		13c. CITY OR TOWN Terra Alta			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 203 Aurora Street 99999		
14. FATHER'S NAME FIRST George		MIDDLE	LAST Gardner	15. MOTHER'S MAIDEN NAME FIRST Amilia			MIDDLE	LAST Hanson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes 11		16b. SOCIAL SECURITY NO. 373-16-6382		17. INFORMANT			ADDRESS Faye E. Gardner, 203 Aurora St., Terra Alta, WV 26764				
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA, METASTATIC											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. TO MEOLASTINUS + NECK											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/19/83 to 11/27/83, to whom (I) (we) last saw the deceased alive on 10/19/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Dr. James Raver		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 11/28/83			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver		22f. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-30-83		23c. NAME OF CEMETERY OR CREMATORIAL Terra Alta Cemetery			23d. LOCATION CITY OR TOWN Terra Alta, WV		COUNTY		STATE
24. FUNERAL DIRECTOR John R. Whelchak		ADDRESS Terra Alta, WV 26764			24e. DATE REC'D. BY REGISTRAR DEC 13 1983			24f. REGISTRAR'S SIGNATURE John R. Whelchak			

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Culicoides sp.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial/travel permit. Then please remove carbon paper. Please, I must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as item 18-shoers any injury, or other traumatic event, the medical examiner shall be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

28470

1. DECEASED NAME (TYPE OR PRINT) SHIRLEY FOOTE GILES			2a. DATE OF DEATH MONTH DAY YEAR November 6, 1983	2b. HOUR P. 5:55 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 22, 1929	6. AGE (IN YEARS LAST BIRTHDAY) 54	# UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE - STATE OR FOREIGN COUNTRY Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital	12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	13. KIND OF BUSINESS OR INDUSTRY In Own Home	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 531 Fort Ave. 21502				
14. FATHER'S NAME FIRST MIDDLE LAST Felix Foote, Sr.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 218-24-8572	17. INFORMANT Mr. William E. Giles, Cumberland, Md. Husband	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line from Part 1b and Part 2b)				
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5163 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). Gardopulmonary Arteritis DUE TO, OR AS A CONSEQUENCE OF (b) Primary Pulmonary Fibrosis (c) Sjögren's-Schönlein-Henoch syndrome				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Anemia, Hypertension, Diabetes				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/>	22b. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC. Mr. J.	22c. LOCATION STREET CITY OR TOWN COUNTY STATE	22d. DATE SIGNATURE 11-20	
22e. I certify that (i) this hospital deceased from (ii) the deceased died on Oct. 12, 1983, to Nov. 6, 1983, that (i) (we) last saw the deceased alive on Oct. 12, 1983, and that in [my] (our) opinion death occurred on the date and hour and from the causes stated above. If we (do) did not view the body after death.				
22f. SIGNATURE <i>Dr. Terry Williams</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22g. DATE SIGNED 11-20	
22h. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams	22i. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-9-1983	23c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park	23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.	23e. DATE REC'D. BY REGISTRAR NOV 14 1983
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.	ADDRESS	25. REGISTRAR'S SIGNATURE <i>George C. Smith</i>		



FD-302 (Rev. 1-25-64) GSA GEN. REG. NO. 27-10000
FBI - MEMPHIS, Tennessee - File Number 16601-9-11

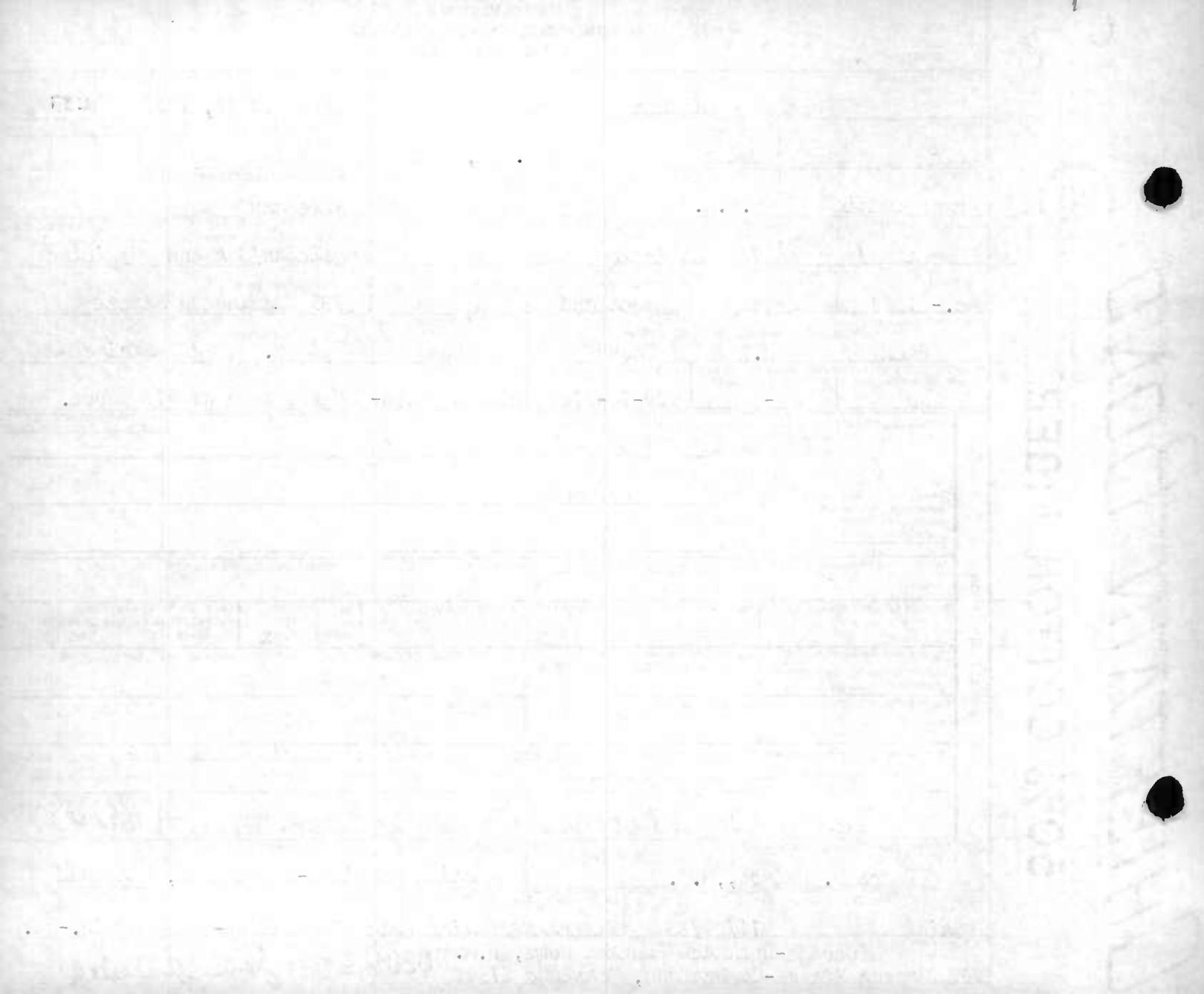
First found at 801 N. Main, at 10th Street, Memphis, Tennessee.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, it may be used as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												28471		
												REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Donald Birtner			Grove			November 27, 1983			2:37 AM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White			Sept. 14, 1905			78 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED X NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Pennsylvania			U.S.A.						Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland			735 Washington Street			Physician/Surgeon			Medicine			21500		
13a. STATE Md. -21502			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 735 Washington Street		
14. FATHER'S NAME FIRST Fred			MIDDLE R.			15. MOTHER'S MAIDEN NAME FIRST Nora			MIDDLE V.			LAST Steigelman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			220-16-6182			Gladys Grove-Address same as #13 above.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Myocardial infarction		
4148														
DUE TO, OR AS A CONSEQUENCE OF (b) CAD.														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												Ca noctate		
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
												CITY OR TOWN		
22a. I certify that (I) (we) attended the deceased from saw the deceased alive on 11/15/83 19 to 11/21 19 83, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Peter B. Halmos, M.D.			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 11/28/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			Memorial Hospital-Cumberland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE		
Burial			11/29/83			Hillcrest Burial Park			Cumberland-Allegany Co.-Md.					
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
George Upchurch Funeral Home, P.A.														
202 Greene Street-Cumberland, Maryland 21502														

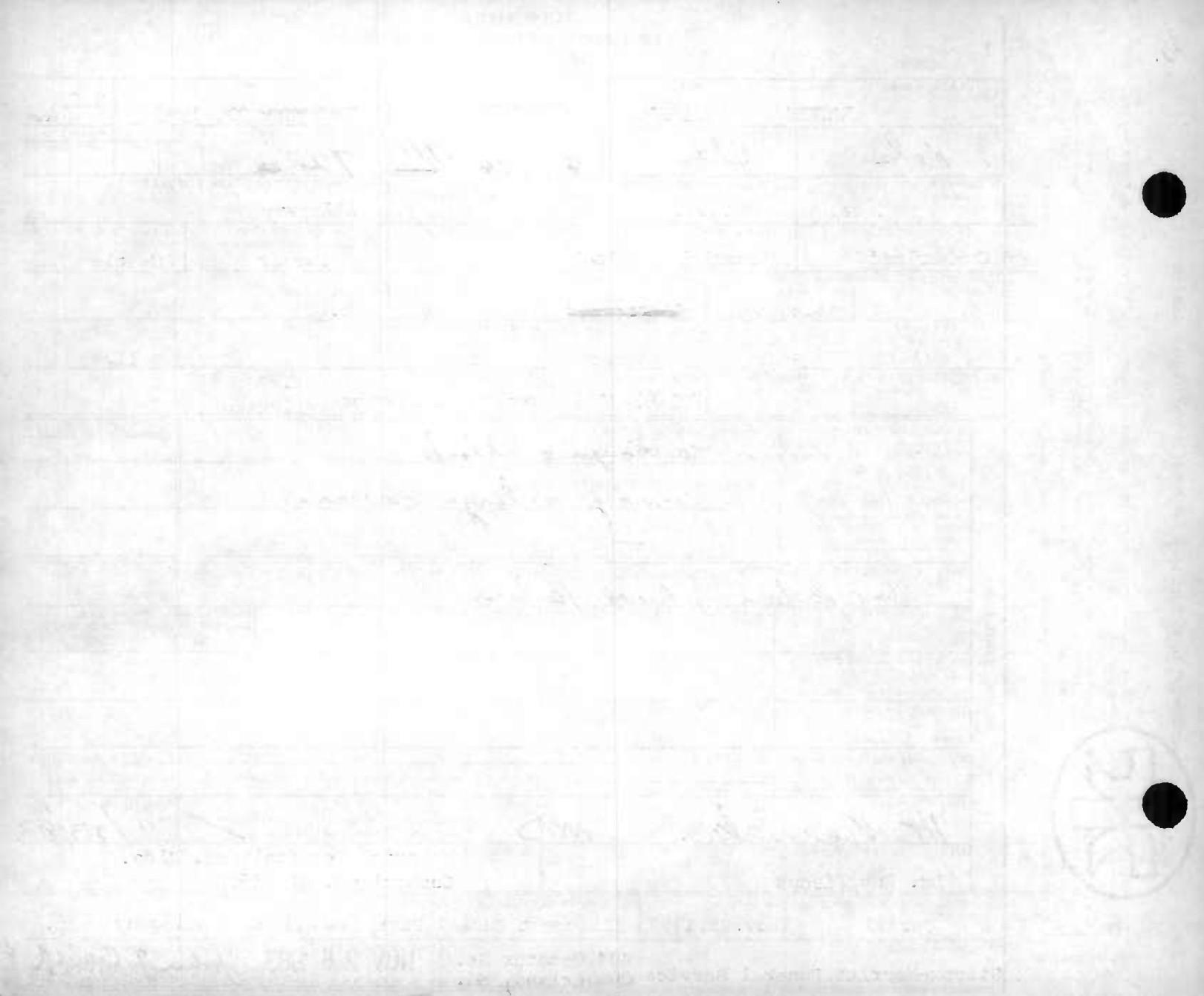


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 28472				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR November 23, 1983							2b. HOUR 8:25 A.M.				
1. DECEASED NAME (TYPE OR PRINT) JUSTIN HARMON HEAVNER			5. DATE OF BIRTH MONTH DAY 1981 June 16 1910							6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.				
3. SEX Male			4. RACE White			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Cattle	
13a. STATE Md.			13b. COUNTY Allegany			13c. CITY OR TOWN Flintstone			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #2 21530			
14. FATHER'S NAME FIRST William MIDDLE Perry LAST Heavner			15. MOTHER'S MAIDEN NAME FIRST Zella MIDDLE Dolly LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 703-07-9255			17. INFORMANT Evelyn B. Heavner			18. ADDRESS Rt. #2 Flintstone					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio genic shock</u> <u>4149</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary artery disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>hypertension, renal failure</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11/23/83				
22b. SIGNATURE <u>H.C. Merrick</u> . MD			22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Guy Fiscus			22f. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 26, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park			23d. LOCATION CITY OR TOWN Cumberland COUNTY Allegany STATE Md.					
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service			25a. ADDRESS 404 Decatur St. Cumberland, Md.							25b. DATE REC'D. BY REGISTRAR NOV 28 1983				
										25b. REGISTRAR'S SIGNATURE <u>John J. Lainey</u>				



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28473

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
ZELMA	May		HEBB	11	1	83	0859	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
FEMALE	WHITE	MONTH 06 DAY 23 YEAR 05	78
		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
US	US		ALLEGANY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housekeeper	

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
MARYLAND	ALLEGANY	CUMBERLAND		105 INDEPENDENCE STREET

14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST
Ernest			Seaber	Minnie			Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	216-22-5543	Deanna Sherman	8150 E. Osborne Road Scottsdale, Arizona 85251

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4019 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b),	DUE TO, OR AS A CONSEQUENCE OF VENTRICULAR FIBRILLATION		
	DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION, SEVERE		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
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22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Richard Schindler</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-1-83
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RICHARD SCHINDLER</i>	22e. ADDRESS 69 GREENE ST (CUMBERLAND), MD.
---	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov 3, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION CITY OR TOWN Cumberland Allegany Maryland
--	--------------------------	--	---

24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service.	ADDRESS 404 decatur St Cumberland, md	25a. DATE REC'D. BY REGISTRAR NOV 04 1983	25b. REGISTRAR'S SIGNATURE <i>Dee Cawie</i>
---	---	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be dated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/76
(VR A 15 (4))

14

STATEMENT OF

CONTRACTOR TRADING COMPANY

RECEIVED

RECEIVED ON THIS DAY

RECEIVED ON THIS DAY

RECEIVED ON THIS DAY

19-11

IN (amount) is paid to

Mr. A. J. D.

IN (amount)

The death certificate be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The |
retained by the hospital or attending physician

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR 217 WINCHESTER AVE. MOOREFIELD W.V.			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			28474	
						REG. NO.	
I. DECEASED NAME (TYPE OR PRINT) JOSEPH EARL HIGH			2a. DATE OF DEATH NOVEMBER 19, 1983			2b. HOUR 6:50A M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1902	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hardy Co., W.Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
13a. STATE W.Va.			13c. CITY OR TOWN Mineral Ridgeley			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rt. Farmer	
14. FATHER'S NAME FIRST Frederick			LAST High			12b. KIND OF BUSINESS OR INDUSTRY General	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 236-58-0928			17. INFORMANT ADDRESS Denver High, Rt#1, B-114, Ridgeley, WV. 26753	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) Atherosclerosis				
{ DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
COPD acute bronchitis CTF							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Mazzocco		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-23-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. E. Mazzocco, M.D.		22e. ADDRESS BMG-912 SETON DR. CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 21, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Olivet Cemetery		23d. LOCATION CITY OR TOWN Moorefield	23e. COUNTY Hardy	23f. STATE W.Va.
24. FUNERAL DIRECTOR NAME George K. Chambers, Moorefield, WV,		ADDRESS	25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE George K. Chambers		

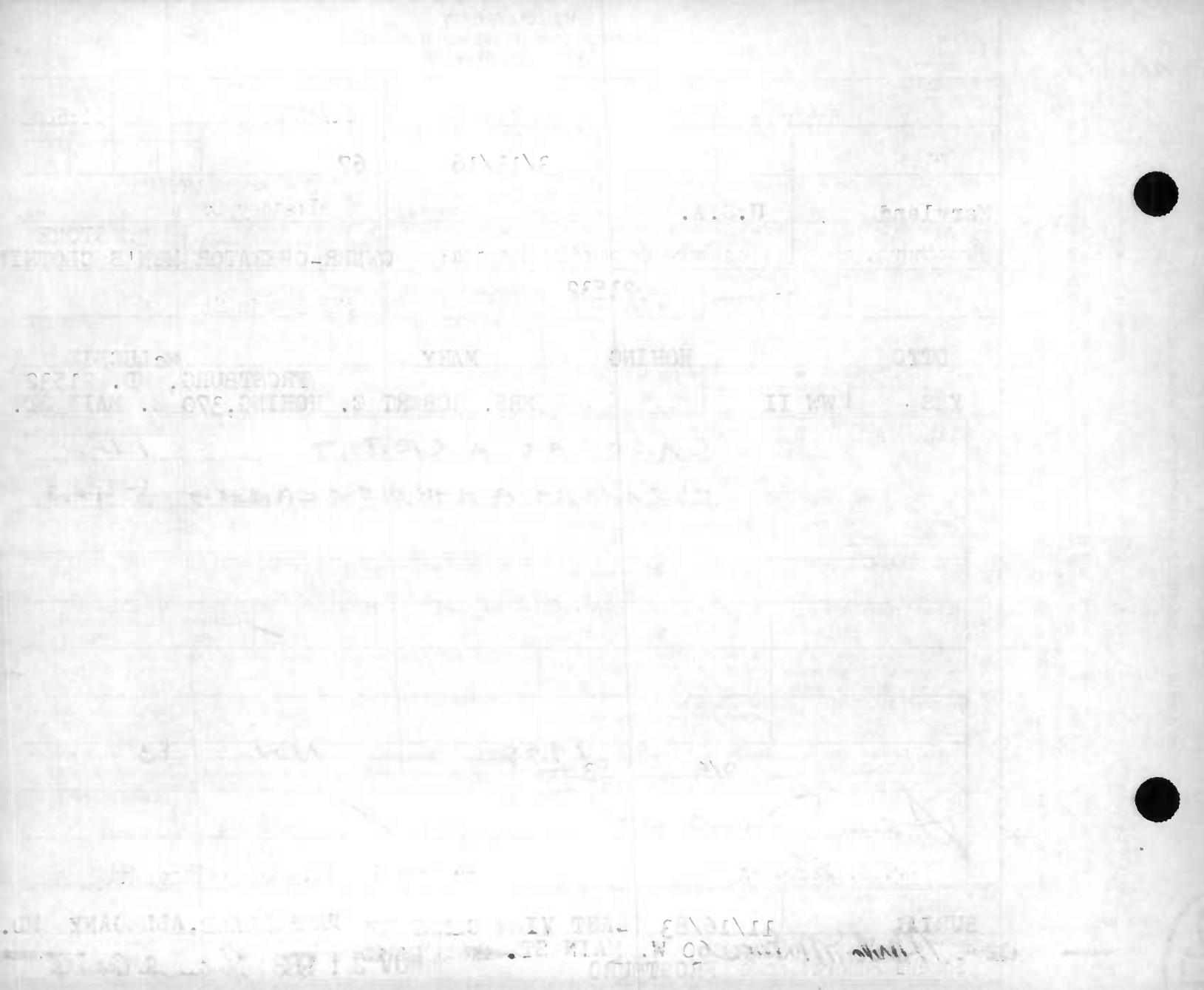
XXIX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28475	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 11/13/83									2b. HOUR 11:52pm	
1. DECEASED NAME (TYPE OR PRINT) Robert C. Hohing			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
3. SEX male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR 3/13/16			6. AGE IN YEARS LAST BIRTHDAY			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co			MD.	
10. CITY OR TOWN OF DEATH Frostburg, MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER-OPERATOR			12b. KIND OF BUSINESS OR INDUSTRY STORE MEN'S CLOTHING				
13a. STATE Md			13b. COUNTY Allegany			13c. CITY OR TOWN Frostburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 320 E Main St 21532	
14. FATHER'S NAME FIRST OTTO			MIDDLE HOHING			15. MOTHER'S MAIDEN NAME FIRST MARY						LAST McLUCKIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT			18. ADDRESS FROSTBURG, MD. 21532			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140			DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERIOSCLEROSIS			DUE TO, OR AS A CONSEQUENCE OF (c)						5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1975, 19, to Nov 19, 1983, that (I) (we) lost saw the deceased alive on 9/6 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dr. S. Jacobson			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Jacobson			22f. ADDRESS 50 Pershing St., Cumberland, Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/16/83			23c. NAME OF CEMETERY OR CREMATORY EAST VIEW CEMETERY			23d. LOCATION CITY OR TOWN CUMBERLAND, ALLEGANY MD.			COUNTY STATE	
24. FUNERAL DIRECTOR John Sowers 60 W. MAIN ST. Sowers Funeral Home FROSTBURG									25a. DATE REC'D. BY REGISTRAR NOV 21 1983			25b. REGISTRAR'S SIGNATURE John S. Carroll	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. IN PENCIL TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 4 FOR YOUR USE. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED WITHIN YOUR PHOTOS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												28416							
												REG. NO.							
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		2b HOUR			
		Harvey Lester Holler												<input checked="" type="checkbox"/> 11-7 83		2030 M			
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d HOUR			
Male		Cau		Jan 26 1891 92			YRS.							11-7 83		2045 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Penns														Allegany			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			616 Sylvan Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Retired Carpenter			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland																	Self Employed		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21502						
Maryland		Allegany		Cumberland						616 Sylvan Avenue									
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			Lybarger								
George					Holler			Sarah											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			616 Sylvan Avenue								
No		214-10-5548			Mrs. Virginia Holler						Cumberland, Md 21502								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4140 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease } DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
Chronic renal disease																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
											YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION														
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Paul Snow</i>		EXAMINER'S NAME (TYPE OR PRINT)			Paul Snow, M.D.			TITLE (SPECIFY) M.D. Ast. Dpty MEDICAL EXAMINER			DATE SIGNED								
Memorial Hospital Cumberland, Md															11-7-83				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE					
Burial		Nov 10, 1983			Hillcrest Burial Park			Cumberland			Allegany			Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS			404 Decatur St			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Silcox-Merritt Funeral Service		Cumberland, Md						NUV 10 1983			<i>John C. Smith</i>								

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR			HAFER FUNERAL HOME 1302 NATIONAL HWY. LAVALE, MD 21502						STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				28471			
1. DECEASED NAME (TYPE OR PRINT)			FIRST NELLIE	MIDDLE BLANCHE	LAST HOLLER	2a. DATE OF DEATH NOVEMBER 4, 1983				REG. NO.	2b. HOUR 12:10AM					
3. SEX FEMALE			4. RACE WHITE		5. DATE OF BIRTH MONTH 04 DAY 02 YEAR 08	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.							
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER				12b. KIND OF BUSINESS OR INDUSTRY FIBER					
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CRESAPTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE SECOND AVENUE 21502					
14. FATHER'S NAME FIRST GEORGE			MIDDLE SIMEON	LAST CLARK	15. MOTHER'S MAIDEN NAME FIRST MARY				MIDDLE ETTA	LAST ROSS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214 07 4522				17. INFORMANT GEORGE W. HOLLER - as above				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> 1809 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Vремя</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer of the Colon George IV</i>																
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Zosimo Gaba</i>			22c. DEGREE						22d. DATE SIGNED							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ZOSIMO GABA, M.D.			22f. ADDRESS 919 SETON DRIVE, CUMBERLAND, MD 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/7/83			23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEM. PARK			23d. LOCATION CITY OR TOWN FROSTBURG, ALLEGANY MD							
24. FUNERAL DIRECTOR NAME JOHN J. HAVER, JR.			25a. DATE REC'D. BY REGISTRAR NOV 8 1983						25b. REGISTRAR'S SIGNATURE <i>John J. Hafer Jr.</i>							
ADDRESS LAVALE, MD																

SHAW JOURNAL READING
CLUB MEMBER'S CARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Forget 1 and 2 should be filled in by the funeral director, page 3, 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed at this time.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28478	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			PEARL GRIFFITH HUDSON						11 07 1983			2042 HRS	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 05 29 92			6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany			MD.	
10. CITY OR TOWN OF DEATH Cumberland Allegany CO			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ALLEG CO NURSING HOME CUMB MD						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 223 Arch St. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel S. Crawford						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie E. Crawford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-16-0512			17. INFORMANT MEMORIAL HOSP			ADDRESS MEMORIAL AVE			CUMBERLAND 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) Chronic obstructive lung disease													
{ DUE TO, OR AS A CONSEQUENCE OF (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Senile dementia													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from April 1983 , to 11-7 1983 , that (I) (we) last saw the deceased alive on 11-7 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 11-8-83	
22b. SIGNATURE Robustiano Barrera						DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robustiano Barrera			22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-10-83			23c. NAME OF CEMETERY OR CREMATORIAL Grantsville Cemetery			23d. LOCATION CITY OR TOWN Grantsville, Garrett, Md.			COUNTY	STATE
24. FUNERAL DIRECTOR NAME D. Lynn Norman			ADDRESS Grantsville, Md.			25a. DATE REC'D. BY REGISTRAR NOV 14 1983			25b. REGISTRAR'S SIGNATURE John J. Conner				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

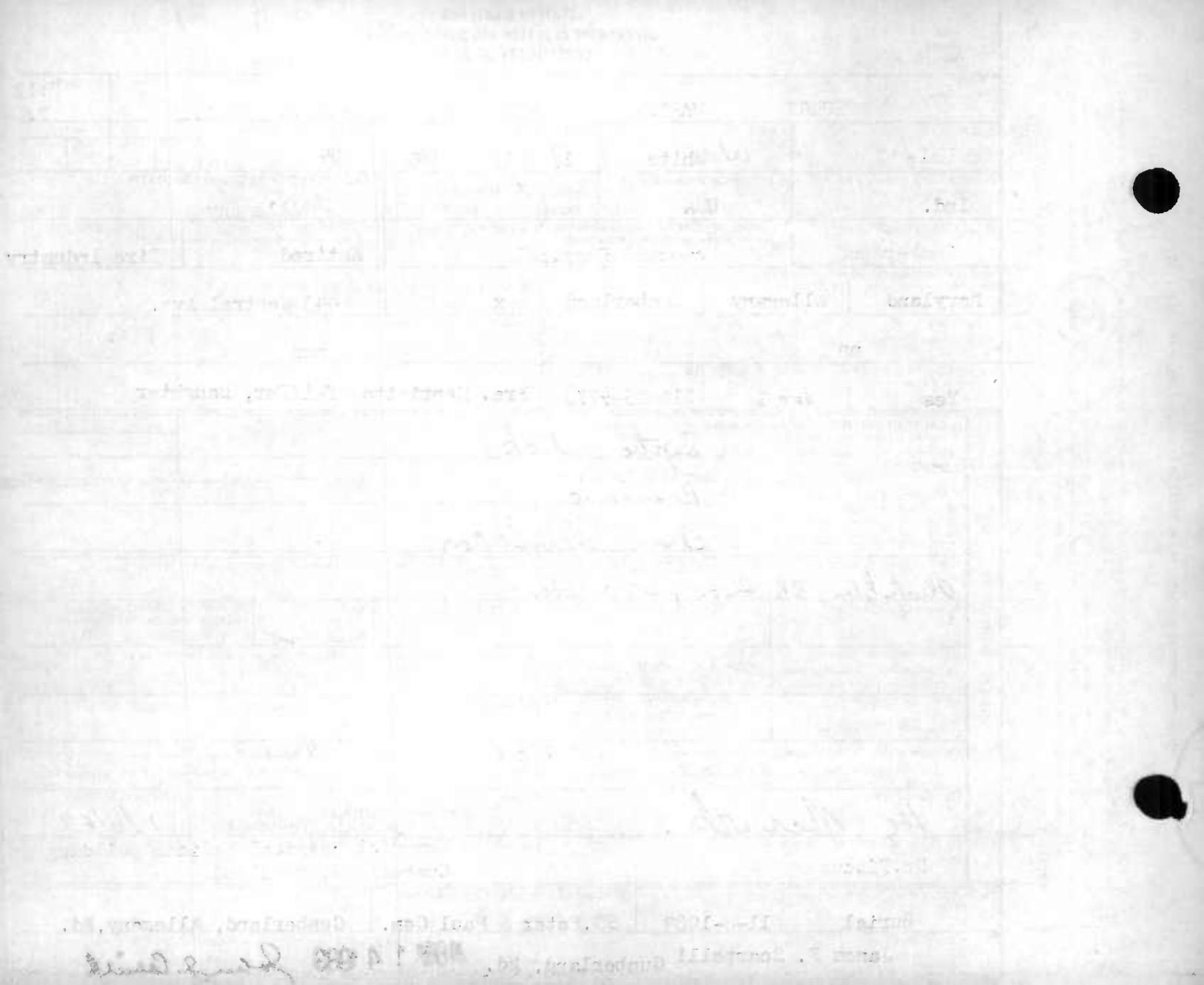
IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND 8 3
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST GEORGE	MIDDLE WALTER	LAST HUFF	2a. DATE OF DEATH November 5, 1983	MONTH YEAR DAY	2b. HOUR 7:12 P.M.
3. SEX Male			4. RACE W White	5. DATE OF BIRTH MONTH 1 DAY 15 YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind.			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION Retired		12b. KIND OF BUSINESS OR INDUSTRY Tire Industry
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 443 Central Ave. 21502
14. FATHER'S NAME FIRST nn MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST nmn MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) War I 214-05-9778			17. INFORMANT Mrs. Henrietta Pfeiffer, Daughter		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic shock</u> 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c) <u>Chronic debilitation</u>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Abraham, Blundess, PTSD, ulcer</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 11/5/83, 19, to 11/5/83, 19, that (I) (we) last saw the deceased alive on 11/5/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>He Merrick.</u>			DEGREE			22c. DATE SIGNED 11/6/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Fiscus			22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-8-1983		23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cem.		23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME James F. Scarpelli		ADDRESS Cumberland, Md.			25a. DATE REC'D. BY REGISTRAR 11/8/83 25b. REGISTRAR'S SIGNATURE <u>James J. Caneff</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH), WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

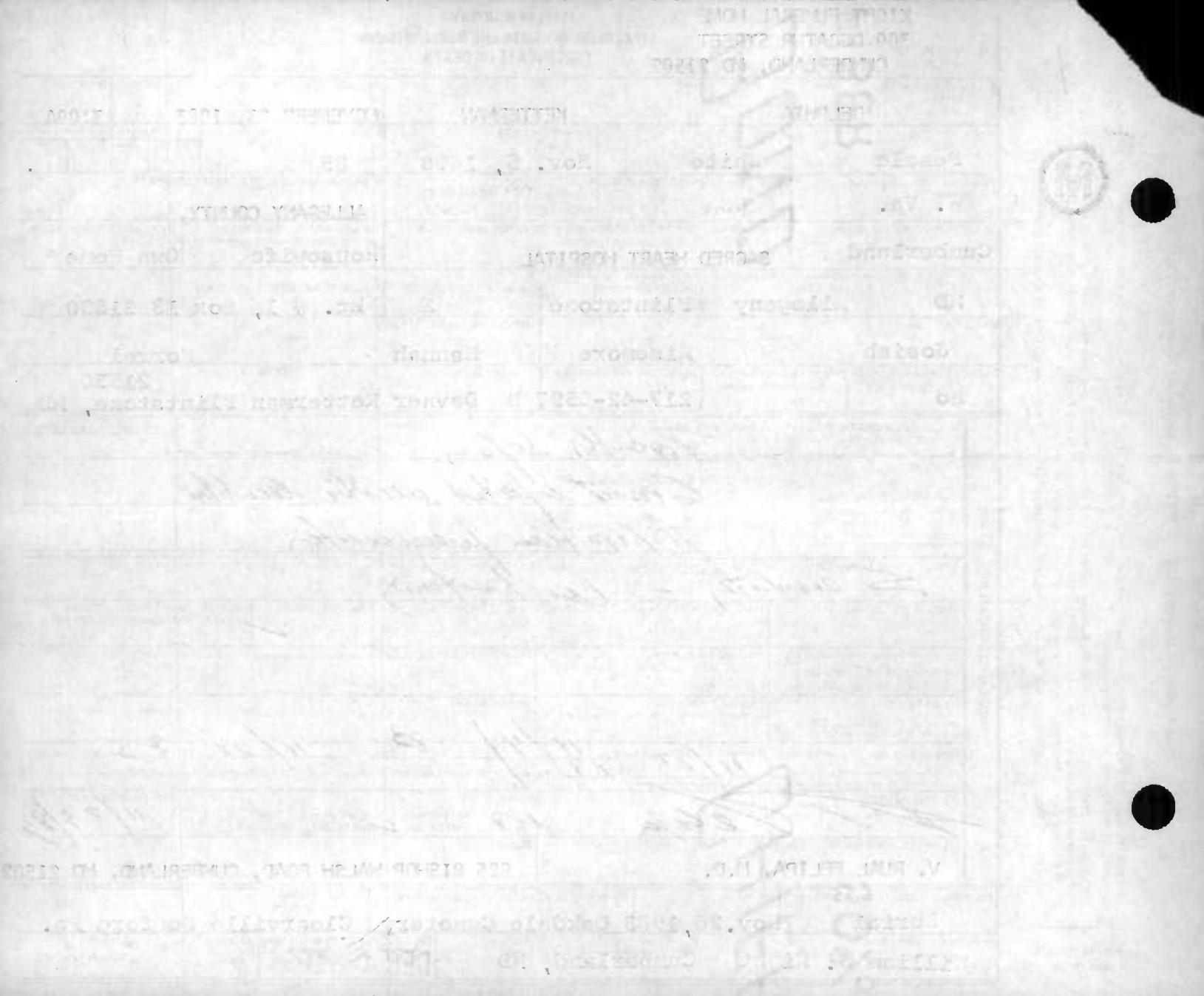
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST OLIVER	MIDDLE DANIEL	LAST JAMISON	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 11	DAY 25	YEAR 1983
3. SEX MALE			4. RACE WHITE	5. DATE OF BIRTH MONTH 06 DAY 02 YEAR 10		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 73	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	2b. HOURS 1501
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE) Trackman			12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. STATE WV			13c. CITY OR TOWN Hampshire Paw Paw			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 99999		
14. FATHER'S NAME Noah			MIDDLE W.	LAST Jamison	15. MOTHER'S MAIDEN NAME Addie Belle Gross						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 232 10 2561			17. INFORMANT Lola Jamison, Paw Paw, WV 25434					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Giovanni Mastrangelo										TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER	
EXAMINER'S NAME Giovanni Mastrangelo, M.D. (TYPE OR PRINT) ADDRESS 900 Seton Drive, Cumberland, Md.										DATE SIGNED 11/25/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/28/83			23c. NAME OF CEMETERY OR CREMATORIUM Woodrow Cemetery			23d. LOCATION CITY OR TOWN Paw Paw COUNTY Morgan STATE WV		
24. FUNERAL DIRECTOR NAME Helsley-Johnson F.H., 306 Union St.						25a. DATE REC'D. BY REGISTRAR DEC 1 1983			25b. REGISTRAR'S SIGNATURE John & Carol		
DHMH-17 (VR A15 ME (5)) 15M2/80											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

KIGHT FUNERAL HOME 309 DECATUR STREET CUMBERLAND, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				2 8 4 8					
								REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				LAST				2a. DATE OF DEATH MONTH DAY YEAR					
DELPHIA				KETTERMAN				NOVEMBER 23, 1983					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				2b. HOUR					
Female		White		Nov. 5, 1898				3:00A M					
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.				6. AGE (IN YEARS LAST BIRTHDAY)					
W. Va.		USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR MONTHS DAYS					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland		SACRED HEART HOSPITAL		Housewife				Own Home					
13a. STATE MD				13b. COUNTY Allegany		13c. CITY OR TOWN Flintstone		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. # 1, Box 13 21530			
14. FATHER'S NAME FIRST Josiah				MIDDLE		LAST Kisemore		15. MOTHER'S MAIDEN NAME FIRST Hannah		MIDDLE		LAST Morrel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		21530					
No		217-42-6597		B Devner Ketterman Flintstone, MD									
18. CAUSE OF DEATH (Enter only one cause per line for Part I and Part II) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probably sepsis</i> <i>5070</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Giant infected necrotic decubitus</i> (c) <i>Brim from pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>S anility - Contraction</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>11/22/83</i> , to <i>11/23/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>11/23/83</i>	
22b. SIGNATURE <i>V. RUAL FELIPA, M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. RUAL FELIPA, M.D.		22e. ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 26, 1983		23c. NAME OF CEMETERY OR CREMATORIY Oakdale Cemetery		23d. LOCATION CITY OR TOWN Clearville Bedford Pa.							
24. FUNERAL DIRECTOR NAME William G. Kight		ADDRESS Cumberland, MD		25a. DATE REC'D. BY REGISTRAR DEC 1 1983		25b. REGISTRAR'S SIGNATURE <i>William G. Kight</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28482					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 11 10 83									2b. HOUR 7:45 PM					
I. DECEASED NAME (TYPE OR PRINT)			FIRST Willard	MIDDLE E.	LAST Lancaster			5. DATE OF BIRTH MONTH 8 DAY 15 YEAR 18			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.						
3. SEX Male			4. RACE White									7. IF UNDER 1 YEAR MONTHS DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) United States			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.								
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Frostburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 255 Welsh Hill 21532					
14. FATHER'S NAME FIRST FRANKLIN			MIDDLE E.			LAST LANCASTER			15. MOTHER'S MAIDEN NAME FIRST DELLA			MIDDLE B.			LAST ROBESON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			16c. INFORMANT D. Nolan			17. ADDRESS 48 Tarn Terrace Frostburg, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Ignamous Cell Carcinoma of Lung & Skin APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. massive liver metastases																	
19a. MEDICAL CERTIFICATION DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ✓			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ✓			21e. LOCATION STREET CITY OR TOWN COUNTY STATE					
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK None			21g. DEGREE			22a. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN			22c. DATE SIGNED 11/11/83								
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Martin M. Rothstein, M.D.			22e. ADDRESS 48 Tarn Terrace Frostburg, MD 21532														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/12/83			23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM. PARK			23d. LOCATION CITY OR TOWN FROSTBURG			23e. COUNTY ALLEGANY					
24. FUNERAL DIRECTOR John M. Sowers SOWERS FUNERAL HOME			ADDRESS 60 W. MAIN ST FROSTBURG			25a. DATE REC'D. BY REGISTRAR NOV 17 1983			25b. REGISTRAR'S SIGNATURE John George Lavelle			STATE MD.					

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CONCRETE
MANUFACTURERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~certified~~ filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please sign page 2 and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be completed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28483					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 11/26/83							2b. HOUR 9 A.M.					
I. DECEASED NAME (TYPE OR PRINT)			FIRST John	MIDDLE 0	LAST Lint	5. DATE OF BIRTH MONTH 1/ DAY 10/ YEAR 98			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
3. SEX male			4. RACE white			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH Frostburg, Md			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RD 3							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BO Policeman			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md			13b. COUNTY Allegany			13c. CITY OR TOWN Frostburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X			13e. STREET ADDRESS Rt 3 Box 471			
14. FATHER'S NAME FIRST Isaac			MIDDLE	LAST Lint	15. MOTHER'S MAIDEN NAME FIRST Mayy			MIDDLE Jane	LAST Hutzel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 705 05 2300			17. INFORMANT Rita Popalo			ADDRESS RD 3 Frostburg, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a CARCINOMA OF THE LEFT LUNG															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>82</u> , to <u>Nov 26</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Nov 10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>S. Chang</u>			22c. DEGREE <u>M.D.</u>							22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S Chang			22e. ADDRESS Broadway, Frostburg, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/28/83			23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery			23d. LOCATION Meyersdale			COUNTY Somerset			STATE Pa.
24. FUNERAL DIRECTOR NAME <u>Leckemby Funeral Home</u>			ADDRESS <u>203 North Street</u>			25a. DATE REC'D. BY REGISTRAR DEC 1 1983			25b. REGISTRAR'S SIGNATURE <u>John G. Conwell</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SCARPELLI FUNERAL HOME FOR 108 VA. AVE. STATE REGISTRAR CUMBERLAND, MD. 21502			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO. 28484		
1. DECEASED NAME (TYPE OR PRINT) BILLIE JEAN LITTLE			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 3, 1983			2b. HOUR 8:10AM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR OCT. 11, 1931		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 52 YRS.		
7c. IF UNDER 1 YEAR MONTHS DAYS			7d. IF UNDER 24 HRS HOURS MIN.					
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.		
13a. STATE Maryland			13b. COUNTY Allegany			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Former Owner		
14. FATHER'S NAME FIRST Robert			MIDDLE Davis			12b. KIND OF BUSINESS OR INDUSTRY Tavern		
15. MOTHER'S MAIDEN NAME Catherine Jenkins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-26-9264			17. INFORMANT ADDRESS Husband Mr. John H. Little, Sr., Cresaptown Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1940			DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (c) Adrenal Adenocarcinoma					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Nov 2 , 19 83 , to Nov 3 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>Wayne Spiggle</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Wayne Spiggle, M.D.		22e. ADDRESS BMG-912 SETON DR. CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-6-1983		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.	COUNTY	STATE
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502		25d. DATE REC'D. BY REGISTRAR NOV 10 1983			25e. REGISTRAR'S SIGNATURE <i>John J. Smith</i>			

COLLECTIVE AGREEMENT
SMA. AV. 801
SUZIE, ST. CALIFORNIA

1981. 3. 10. 10:00 AM

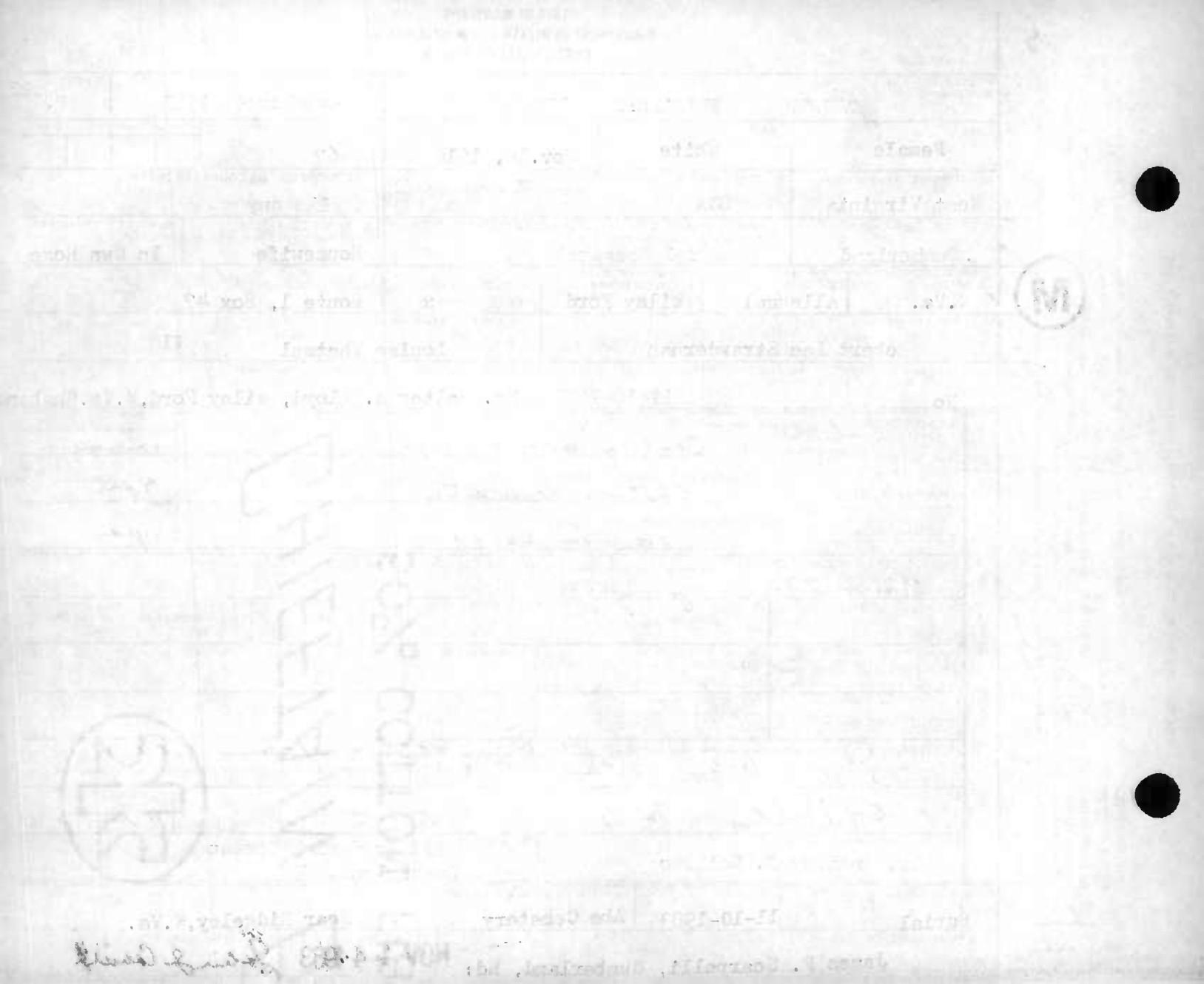
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit's permit. Then please remove carbon papers. Pages 1 and 2 should be detached and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28485	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR November 6, 1983							2b. HOUR 7:37 P.M.	
I. DECEASED NAME (TYPE OR PRINT)		FIRST EVELEE	MIDDLE ELIZABETH	LAST LLOYD	5. DATE OF BIRTH MONTH Nov. 16, 1916 DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
3. SEX Female		4. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home			
13a. STATE W.Va.		13c. COUNTY Mineral		13c. CITY OR TOWN Wiley Ford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 47 99999			
14. FATHER'S NAME FIRST Robert Lee Strawderman		MIDDLE Strawderman		LAST		15. MOTHER'S MAIDEN NAME Louise Whetzel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-7427		17. INFORMANT Mr. Walter A. Lloyd, Wiley Ford, W.Va., Husband		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Electrolyte derangement</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced ASCVD</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 4 hr yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pain precipitated congestive heart failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>11-6</u> , 19 <u>83</u> , to <u>11-6</u> , 19 <u>83</u> , that (1) we last saw the deceased alive on <u>11-6</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE <u>Bollino</u>		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 7 Nov 83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony J. Bollino		22e. ADDRESS 955 Frederick Street Cumberland, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-10-1983		23c. NAME OF CEMETERY OR CREMATORIAL Abe Cemetery		23d. LOCATION CITY OR TOWN Near Ridgeley, W.Va.		COUNTY STATE			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR NOV 1-4 1983 REGISTRAR'S SIGNATURE <u>John J. Corrigan</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (Pages 1 and 2 should be filled within 24 hours after death), then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene, P.O. Box 1904, Baltimore, Maryland, or removed.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ST. COX/MERRITT FUNERAL HOME STATE OF MARYLAND
404 DECATUR STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

REG. NO. 28486

1. DECEASED NAME (TYPE OR PRINT)			FIRST JAMES	MIDDLE ELMER	LAST MALLOW	2a. DATE OF DEATH NOVEMBER 21, 1983	MONTH NOVEMBER	DAY 21	YEAR 1983	2b. HOUR 8:25 P.M.				
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Aug. 3, 1904			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Petroleum					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pa.			13b. COUNTY Bedford			13c. CITY OR TOWN Hyndman			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. # 1 99999		
14. FATHER'S NAME FIRST Jacob			MIDDLE W.			LAST Mallow			15. MOTHER'S MAIDEN NAME FIRST Annie			MIDDLE J.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 4100 213-22-3430			17. INFORMANT Sylvia O. Mallow			ADDRESS Rt. #1 Hyndman, Pa. 15545			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hart Diah. Myocardial Infarction</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe Coronary Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i> .														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21/83</u> to <u>11/21/83</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Sylvia Mallow</i>			DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/23/83		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 925 BISHOP WALSH DRIVE, CUMBERLAND, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 25, 1983			23c. NAME OF CEMETERY OR CREMATORIUM Glendale Cemetery			23d. LOCATION CITY OR TOWN Flintstone			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Silcox-Merritt Fun'l Ser. Cumb.			24b. ADDRESS 404 Decatur St. Md.						25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conigli</i>		

CHICAGO, ILLINOIS
CHICAGO, ILLINOIS

111 N. Wacker Drive

CHICAGO, ILLINOIS

CHICAGO, ILLINOIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

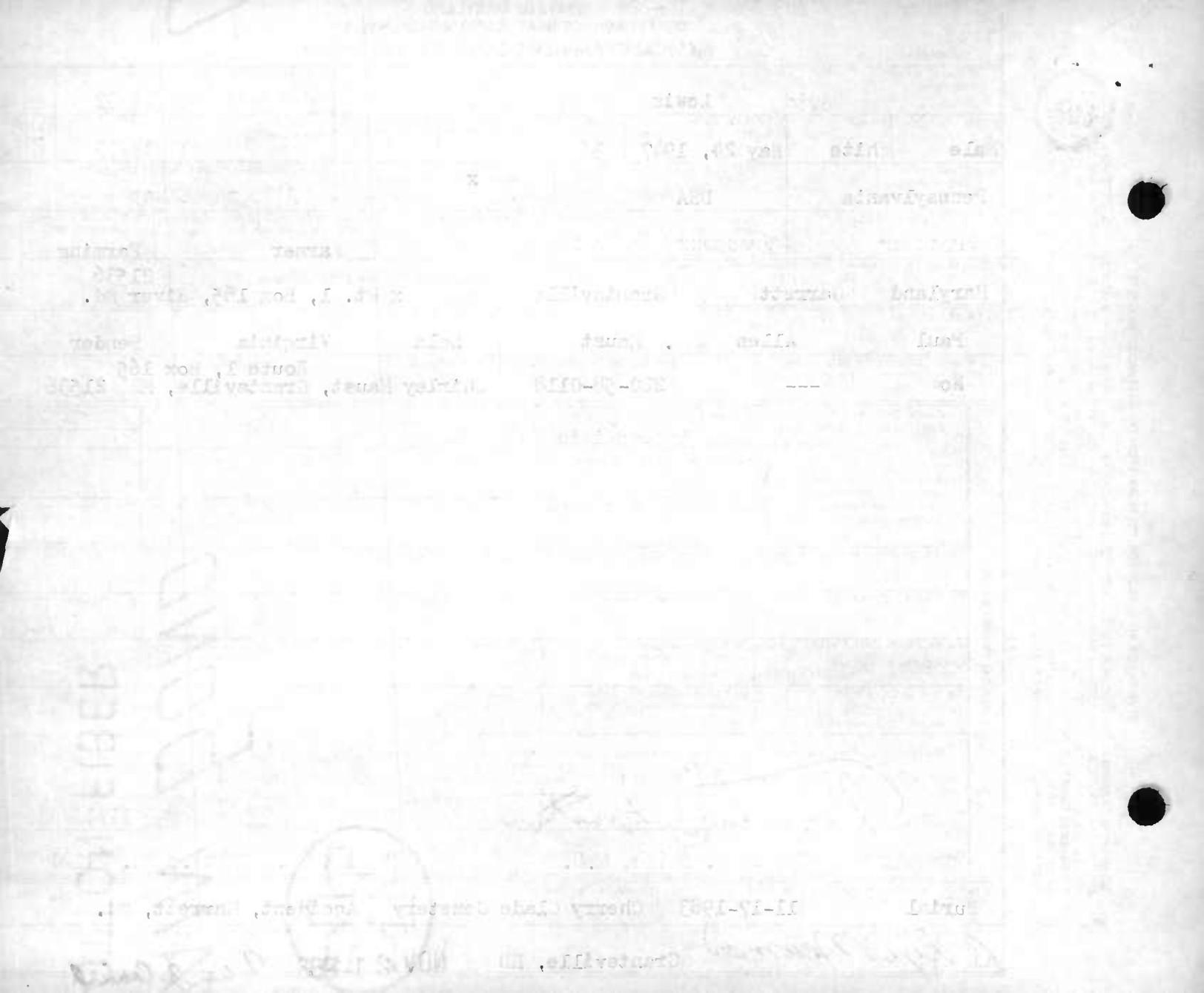
MEDICAL CERTIFICATION
99

FOR NEWMAN FUNERAL HOME 1 - STATE P.O. BOX 267, GRANTSVILLE, CERTIFICATE OF DEATH REGISTRAR MD.					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					28481						
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH NOVEMBER 10, 1983					MONTH	DAY	YEAR	2b. HOUR 10:50PM		
JOHN WALTER MARGROFF																
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS					IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.								
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer					12b. KIND OF BUSINESS OR INDUSTRY Dairy Farming			
13a. STATE Maryland			13b. COUNTY Garrett		13c. CITY OR TOWN Accident			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 14, 21520					
14. FATHER'S NAME FIRST Franklin			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Matilda			MIDDLE	LAST	16. ADDRESS Route 2, Box 14			Zehner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-16-2097					17. INFORMANT Esther Margroff, Accident, Md. 21520								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4280			Congestive Heart Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) _____					(c) _____								
DUE TO, OR AS A CONSEQUENCE OF																
DUE TO, OR AS A CONSEQUENCE OF																
DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <i>Gary Wagoner MD</i>			22c. DEGREE					22d. DATE SIGNED 11-11-83								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GARY WAGONER			22f. ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 14, 1983		23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery			23d. LOCATION CITY OR TOWN Accident, Garrett, Md.								
24. FUNERAL DIRECTOR NAME <i>D. Lynn Newman</i>			ADDRESS Grantsville, Md.					25a. DATE REC'D. BY REGISTRAR NOV 17 1983					25b. REGISTRAR'S SIGNATURE <i>John J. Coyle</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
David Lewis Maust						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11/13/83			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	White	May 24, 1947	36 yrs.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11/13/83			8:50 p.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania		USA						Allegany County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frostburg		Frostburg Community Hospital			Farmer			Farming				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21536		
Maryland		Garrett		Grantsville				Rt. 1, Box 165, River Rd.				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
		Paul	Allen	Maust	Lela			Virginia Bender				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No		220-58-0118			Shirley Maust, Grantsville, MD 21536			Route 1, Box 165				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF 4290 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <input checked="" type="checkbox"/> Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Thomas D. Smith</u> TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.			ADDRESS			DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		11-17-1983		Cherry Glade Cemetery			Accident, Garrett, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
John Lynn Newman		Grantsville, MD			NOV 21 1983			John J. Smith				
BP 363												
OHMH - 17 (VR A15 ME (5))												
20M 4/82												



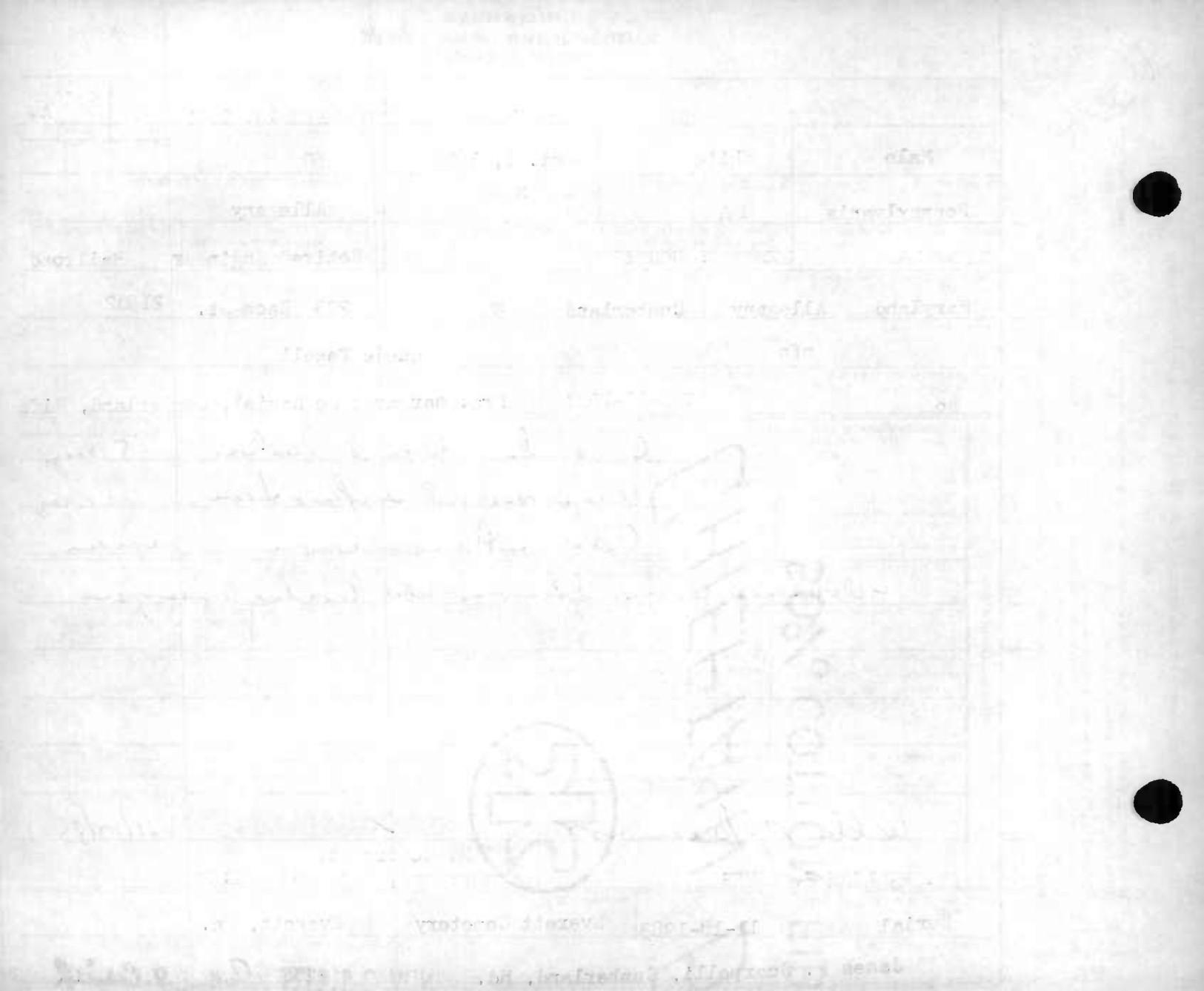
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2 8 4 8 9						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
ALLEN ROSCO McDANIEL						NOVEMBER 16, 1983						6:28 A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male			White			MONTH Oct. 1, 1903 YEAR			80			IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS		DAYS	HOURS	MIN.
Pennsylvania			USA						Allegany MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND			MEMORIAL HOSPITAL			Retired Engineer			Railroad							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			223 Race St. 21502						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
			nnn			Maude Tewell										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			705-10-7057			Mrs. Margaret Mc Daniel, Cumberland, Wife										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										5 days						
DUE TO, OR AS A CONSEQUENCE OF (b) Uncontrolled Infection										5 days						
DUE TO, OR AS A CONSEQUENCE OF (c) Col. ulcer										year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
Advanced Aortic Disease, Abd. Cardiac Arrest																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH?							
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Weller P. James Jr.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/17/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM P. JAMES			22e. ADDRESS 441 N. Centre St. Cumberland, Maryland 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-18-1983			23c. NAME OF CEMETERY OR CREMATORIAL Everett Cemetery			23d. LOCATION CITY OR TOWN Everett, Pa.			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 21 1983			25b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>							

BP_____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE IT TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 3 AND 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28490

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR M.	
James Burton McIntyre						11	2	19	83	5 P	
3 SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR					
Male	White	12 26 1908	74 yrs.			11	2	19	83	6 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.				
Maryland		U.S.A?									
10. CITY OR TOWN OF DEATH Lonaconing		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9 Island St. Lonaconing Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Electrician		12b. KIND OF BUSINESS OR INDUSTRY Westvaco				
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9 Island St. 21539					
14. FATHER'S NAME FIRST James		MIDDLE McIntyre	LAST		15. MOTHER'S MAIDEN NAME FIRST Nellie		MIDDLE Russell	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO. 062-07-2720		17. INFORMANT Emily McIntyre		ADDRESS 9 Island St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> 4140 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. { DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											DATE SIGNED 11-4-83
ACTUAL SIGNATURE Nicholas Giacinto, M.D.		TITLE (SPECIFY) Deputy MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) NICHOLAS GIACINTO		ADDRESS 900 STONDR. CUMBERLAND									
23a. BURIAL/CREMATION/REMOVAL (SPECIFY) Burial		23b. DATE 11/5/83		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland		COUNTY Allegany		STATE Maryland	
24. FUNERAL DIRECTOR NAME Boals Funeral Service P.A.		25. DATE REC'D. BY REGISTRAR 25a. REGISTRAR'S SIGNATURE John J. Conner		25b. DATE REC'D. BY REGISTRAR NOV 14 1983							
BP _____											
DHMH - 17 IVR A15 ME(5) 15M 7/76											

West Bend

200 ft. N.

20 ft.

20 ft.

20 ft.

20 ft.

20 ft.

20 ft.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 28491
1 - FOR STATE REGISTRAR						
I. DECEASED NAME (TYPE OR PRINT)		FIRST LYDIA	MIDDLE ALICE	LAST MCKEE	2a DATE OF DEATH NOVEMBER 17, 1983	2b. HOUR 10:41 pm
3. SEX FEMALE		4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 19, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress	12b. KIND OF BUSINESS OR INDUSTRY Tailor Shop
13a. STATE Md.		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Linden St.	21502
14. FATHER'S NAME FIRST Landon		MIDDLE Racey	LAST	15. MOTHER'S MAIDEN NAME FIRST Hannah	MIDDLE Groves	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-24-6670		17. INFORMANT Mrs. Wanda Davidson, Cumberland, Md. Daughter	ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sept. cancer</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTO PST? <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURAL DEATH IN THIS ITEM) 10/9/83		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED 11/18/83	
22a. I certify that (if this hospital) attended the deceased from <i>10/9/83</i> to <i>11/17/83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Guy Fiscus</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. GUY FISCUS		22d. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-21-1983	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.	25a. DATE REC'D. BY REGISTRAR NOV 23 1983
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		ADDRESS		25b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>		
DHMH - 16 50M 4/82 (VRA 15, 4)						

200/5

34.00000

100% Production

negative Margin

positive Margin



100% Cull

100% negative Margin 100% Internal Control 100% Positive Margin

100% Internal Control 100% Positive Margin

33

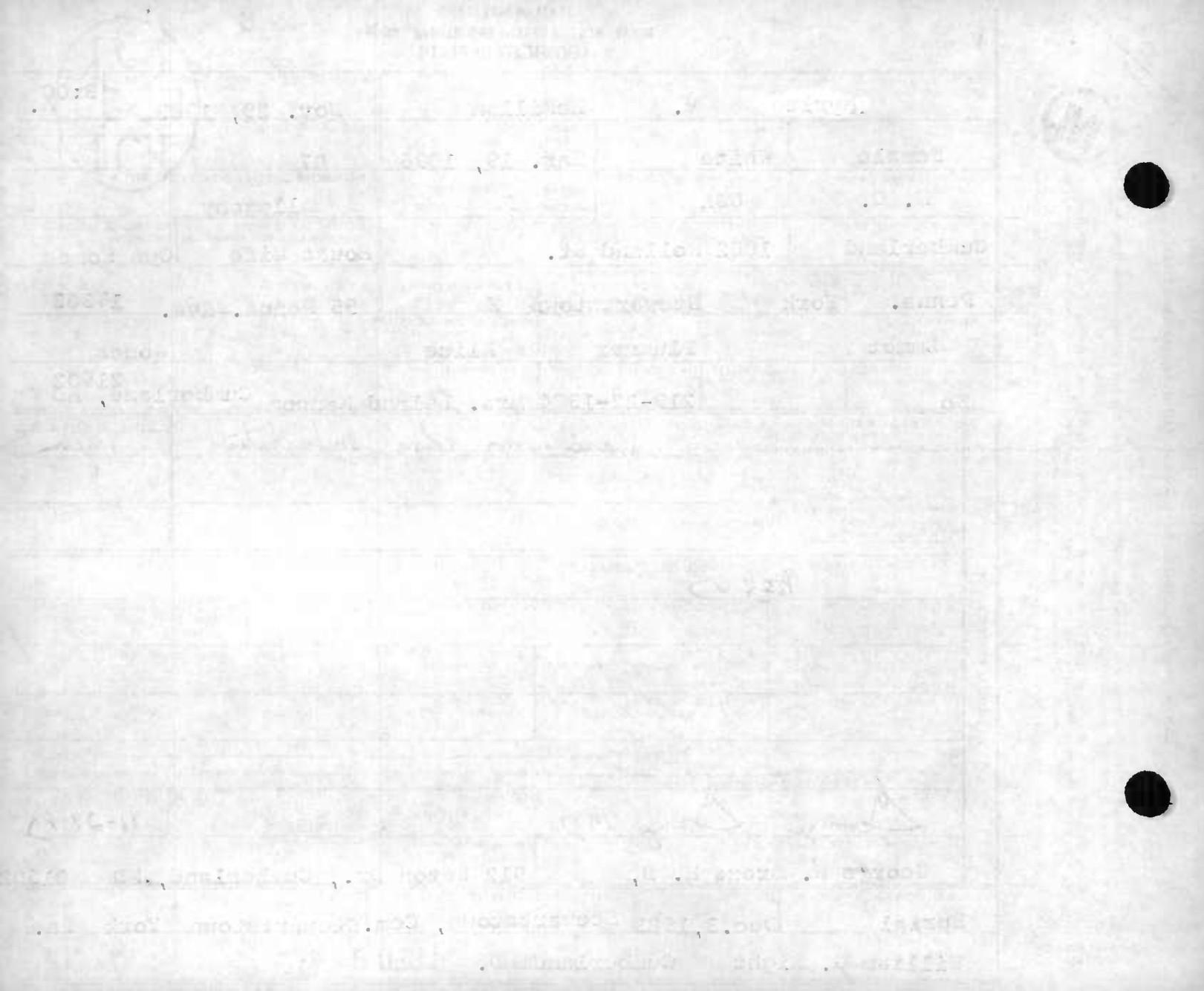
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 2 8 4 9 '2	
REG. NO.												3:00 A.M.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Myrtle V. McMillan						Nov. 29, 1983			3:00 A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				
Female			White			Mar. 19, 1896			87 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
N. C.			USA						Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			1002 Holland St.			House Wife			Own Home				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Penns.			York			Stewartstown			13e. STREET ADDRESS 55 Penna. Ave. 17363				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 219-22-1384				
Emmet			Plummer			17. INFORMANT Mrs. Leland Ransom			ADDRESS 21502 Cumberland, MD				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma colon, metastatic</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
1539 18c. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ASCLD</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <i>George Breza MD</i>	
22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 912 Seton Dr., Cumberland, MD 21502			22e. DATE SIGNED 11-29-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 3, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Stewartstown, Cem. Stewartstown			23d. LOCATION CITY OR TOWN County State York Pa.	
24. FUNERAL DIRECTOR NAME William G. Kight			ADDRESS Cumberland MD.			25a. DATE REC'D. BY REGISTRAR DEC 8 1983			25b. REGISTRAR'S SIGNATURE <i>John G. Canfield</i>				



NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the 24-hour death book with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28493	
1. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	
HAROLD WILLIAM METZ (SR)				NOVEMBER 27, 1983	
3. SEX Male				2b. HOUR 8:05 AM	
4. RACE White				6. AGE (IN YEARS LAST BIRTHDAY) 76 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
5. DATE OF BIRTH MONTH March DAY 12, YEAR 1907				7. BIRTHPLACE STATE OR FOREIGN COUNTRY W. Va.	
7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Cumberland				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUTNY MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iron Worker	
13a. STATE W. Va. 13c. CITY OR TOWN Ft. Ashby				12b. KIND OF BUSINESS OR INDUSTRY Construction	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE Rt. 46, P. O. Box 45 99999	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Harry Metz				Sarah Margaret Powell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 233 03 5118	
17. INFORMANT Mrs. Harold W. Metz, Sr				P. O. Box 45 Ft. Ashby, WV	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629				ADDRESS	
DUE TO, OR AS A CONSEQUENCE OF (b) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (c) _____				6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) abdominal aortic aneurysm					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 11/24/1983 to 11/27/1983, that (I) (we) last saw the deceased alive on 11/27/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED 11/29/83	
A. SIVAN PILLAI, MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		915 SETON DRIVE, CUMBERLAND, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 30, 1983		23d. LOCATION CITY OR TOWN Ft. Ashby, Mineral, W. Va.	
24. FUNERAL DIRECTOR John L. Keyser, W. Va. Markwood Funeral Home, 1119. Mineral St.		25a. DATE REC'D. BY REGISTRAR Dec 5 1983		25b. REGISTRAR'S SIGNATURE John L. Comer	

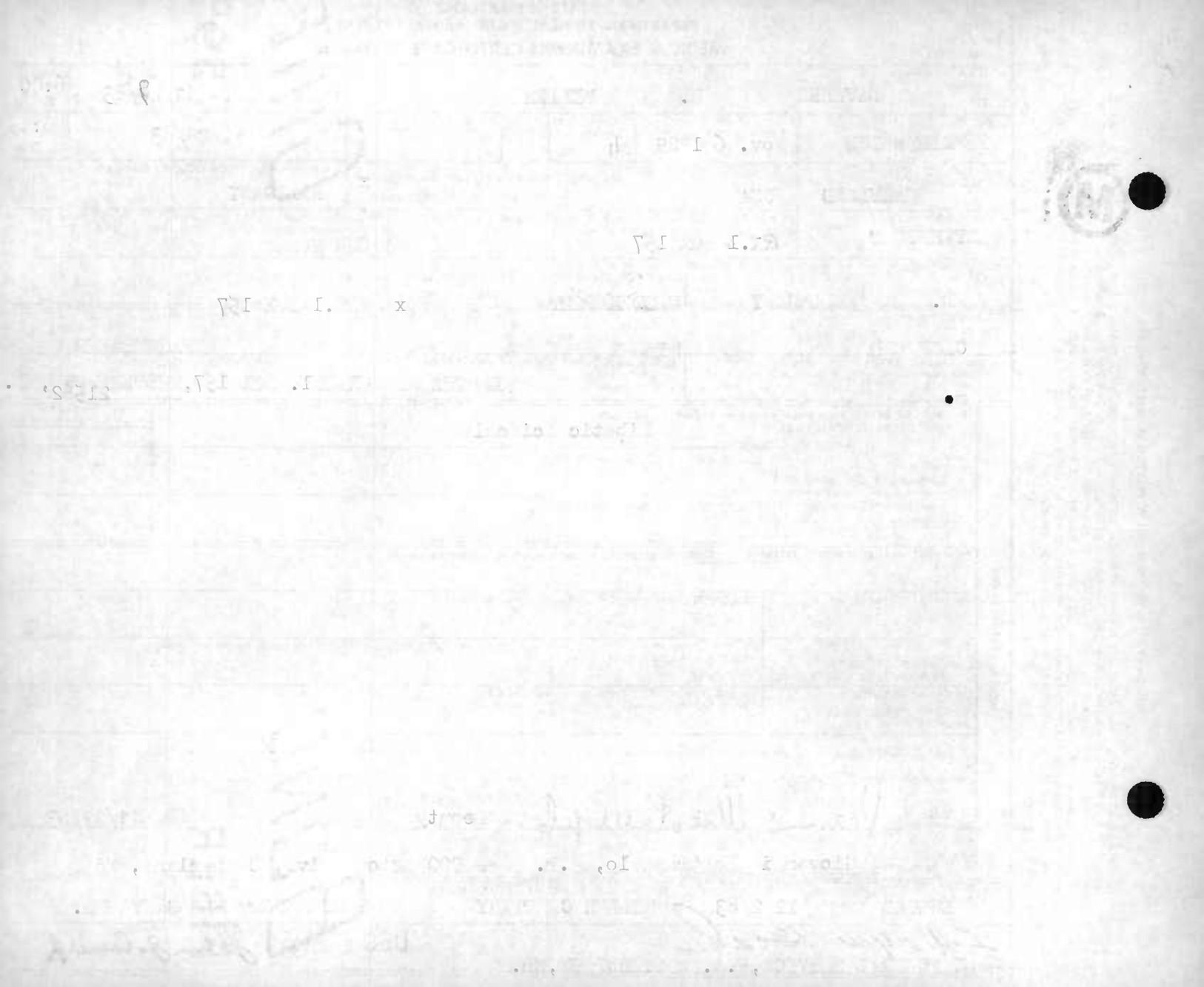
TO MEDICAL EXAMINER. THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2 AND 3 TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOBM, PM, 3 RETAIN PAGE 3 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PINE ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH28494
REG. NO.

I. DECEASED NAME (TYPE OR PRINT)		FIRST LAVERNE	MIDDLE R.	LAST MILLER	2d. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11/29/83	MONTH YEAR 1983	2d. HOUR 6:00 a.m.		
J. SEX FEMALE	RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Nov. 8 1929	6. AGE (IN YEARS LAST BIRTHDAY) 54 yrs.	7. IF UNDER 1 YR. MONTHS 5	8. IF UNDER 24 HRS. HOURS 0	9. IF UNDER 24 HRS. MIN. 0	2e. DATE PRONOUNCED DEAD 11/29/83	MONTH DAY YEAR 1983	2d. HOUR 6:00 p.m.
a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	b. CITIZEN OF WHAT COUNTRY? USA	c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	d. 9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY						
10. CITY OR TOWN OF DEATH WESTERNPORT	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT. 1 BOX 157			12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWN HOME			12b. KIND OF BUSINESS OR INDUSTRY FAZENBAKER		
13e. STATE MD.	13b. COUNTY ALLEGANY	13c. CITY OR TOWN WESTERNPORT	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RT. 1 BOX 157	13f. STREET ADDRESS 21562	13g. STREET ADDRESS 21562	13h. STREET ADDRESS 21562	13i. STREET ADDRESS 21562	
14. FATHER'S NAME FIRST CLIFFORD	MIDDLE 	LAST MILLER	15. MOTHER'S MAIDEN NAME FIRST BERTHA	MIDDLE 	LAST 	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 	17. INFORMANT BERTHA MILLER RT. 1 BOX 157, WESTERNPORT, MD.	ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Dipetic Acidosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 			
IMMEDIATE CAUSE (a) 2501 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER									
DATE SIGNED 11/29/83									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 900 Seton Drive, Cumberland, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/2/83		23c. NAME OF CEMETERY OR CREMATORY MILLER CEMETERY		23d. LOCATION CITY, COUNTRY WESTERNPORT ALLEGANY MD.			
24. FUNERAL DIRECTOR <i>E. Wayne Boal</i>				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>			
BS									
DHMH - 17 (VR A15 ME (5)) 15M 7/76									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

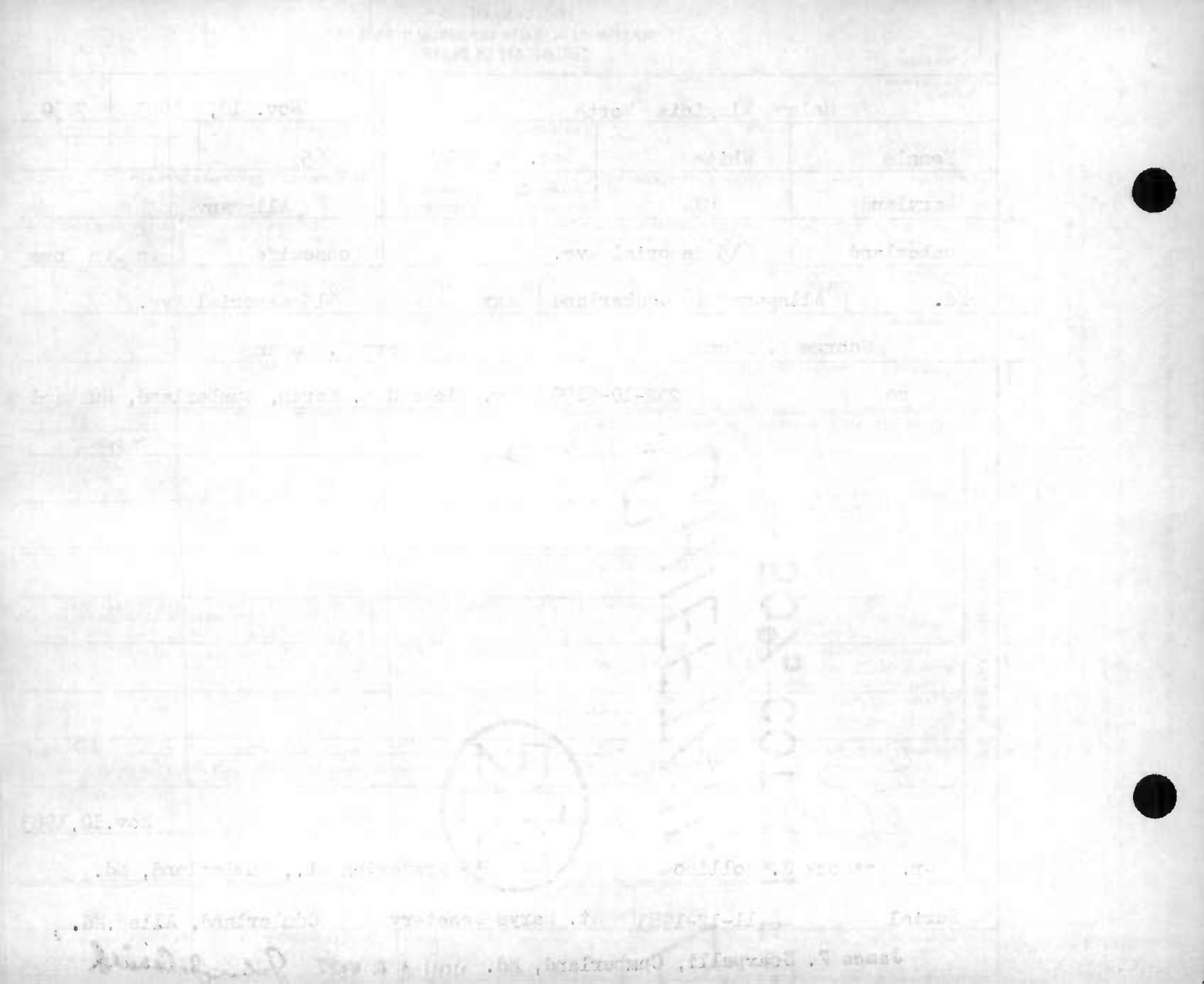
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28495				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			William m. Myers						11-11-83			5 ³⁰ AM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male			white			4 * * * 11			72 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
MARYLAND			U.S.A.						Allegany County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Frostburg			Frostburg Community Hosp						RT. 3, BOX 347, FROSTBURG			12b. KIND OF BUSINESS OR INDUSTRY STATE ROADS				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS			21532				
MARYLAND			ALLEGANY			ECKHART			RT. 3, BOX 347, FROSTBURG							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
WILLIAM H. MYERS			LENA GREEN			NO N.A.			220-03-712			MRS. MARIE SPIKER, RT. 3, BOX 347,			FROSTBURG, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DOUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4241 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Congestive Heart Failure			Arteric Disease						10 minutes				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-15, 1983, to 11-10, 1983, that (II) (we) last saw the deceased alive on 11-11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
MARTIN M. ROTSTEIN M.D.						M.D.						11/11/83				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN							
BURIAL			11/12/83			ECKHART CEMETERY			ECKHART			ALLEGANY, MD.				
24. FUNERAL DIRECTOR SOWERS FUNERAL HOME			ADDRESS			60 W. MAIN ST.			NOV 17 1983			COUNTY STATE ALLEGANY, MD.				
25a. DATE REC'D. BY REGISTRAR'S OFFICE NOV 17 1983																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28496			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR Nov. 10, 1983							2b. HOUR 7:30 M			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST			3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS.		
Female		Helen Virginia North			White		Dec. 6, 1917						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
Maryland		USA											
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 615 Memorial Ave.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home	
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 615 Memorial Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Rogan											
George L. Sluss													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-10-9190		17. INFORMANT Mr. Richard B. North, Cumberland, Husband								ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Caylury</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mn	
<u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)													
} DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (s) (this hospital) attended the deceased from <u>9-3-83</u> , to <u>10 pm</u> , 19 <u>83</u> , that (s) (we) last saw the deceased alive on <u>9-24-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (We) did (did not) view the body after death.													
22b. SIGNATURE <u>Dr. Anthony J. Bollino</u>		22c. DEGREE M.D.								22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED Nov. 10, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony J. Bollino		22e. ADDRESS 955 Frederick St., Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-12-1983		23c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		23d. LOCATION CITY OR TOWN Cumberland, Alleg. Md.		23e. COUNTY Cumberland		STATE Alleg. Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR NOV 16 1983								25b. REGISTRAR'S SIGNATURE <u>James F. Scarpelli</u>			



FREDLOCK FUNERAL HOME
PIEDMONT WVSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 28 491

1- FOR
STATE
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
AGNES C O'BRIEN						NOVEMBER 16, 1983				4:15P M	
3. SEX			4. RACE		S. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White		11	30	93	89	IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.						ALLEGANY COUNTY, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland			SACRED HEART HOSPITAL		Housewife			99999 72 West Hampshire St. 26750			
13a. STATE W V			13b. COUNTY Mineral	13c. CITY OR TOWN Piedmont	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
14. FATHER'S NAME FIRST Patrick			MIDDLE Curran	LAST	15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE Lee	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
No			217-05-1398D		Mrs. James McCutchen		Westernport, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a)			END-stage Metastatic Breast Carcinoma								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DO TO, OR AS A CONSEQUENCE OF (b)								
			DO TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.											
22b. SIGNATURE <i>Gary Wagoner MD</i>		DEGREE			22c. DATE SIGNED 11-16-83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 925 BISHOP WALSH RD. CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial		23c. NAME OF CEMETERY OR CREMATORIAL St. Peter'd Cem.		23d. LOCATION CITY OR TOWN Westernport		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Wm. H. Fredlock		ADDRESS 31 Jones St. Piedmont, W V 26750		25a. DATE REC'D. BY REGISTRAR NOV 25 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Cawich</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

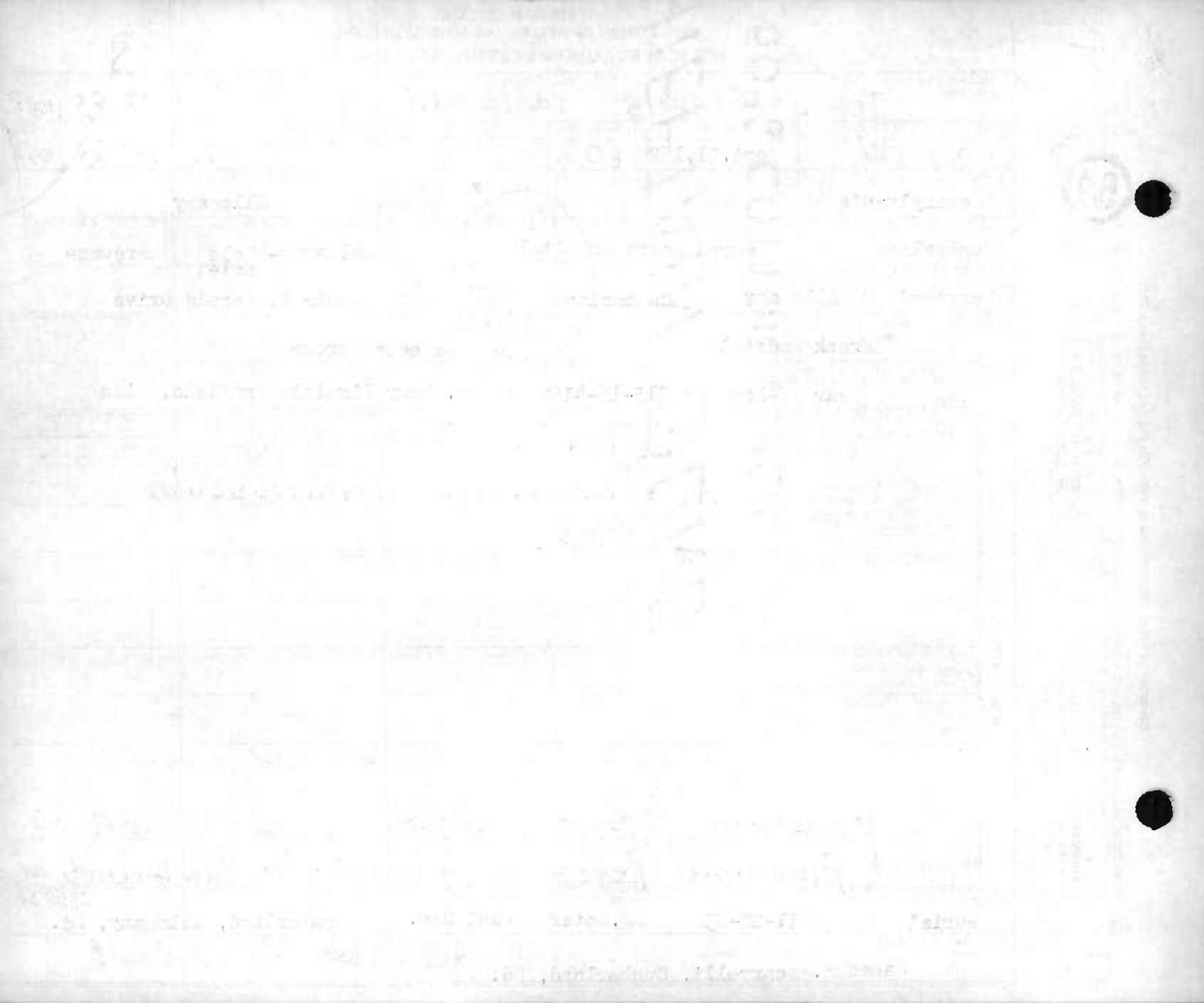
IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner may be notified or summoned.

999999
BP

莫高窟藏经洞

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 28498														
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTIMATED DEATH <input checked="" type="checkbox"/> 11 19 1983									2b. HOUR 1:05 P.M.														
1. DECEASED NAME (TYPE OR PRINT) John Francis Padfield			2. FIRST MIDDLE LAST			3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1923			6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			7. IF UNDER 1 YR. IF UNDER 24 HRS.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			11. CITIZEN OF WHAT COUNTRY? USA			12. DATE PRONOUNCED DEAD 11 19 1983			13. CITY OR TOWN OF DEATH Cumberland			14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman-Whole sale			16. KIND OF BUSINESS OR INDUSTRY Hardware								
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Route 6, Harold Drive			17. INFORMANT Mrs. Mary Virginia Padfield, Wife											
14. FATHER'S NAME FIRST MIDDLE LAST Frank Padfield			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Brown																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 215-16-4183			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. IMMEDIATE CAUSE (a) Due to, or as a consequence of (b) Due to, or as a consequence of (c) Due to, or as a consequence of Myocardial Infarction Arteriosclerotic Cardiovascular Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																										
ACTUAL SIGNATURE Francisco Reyes			TITLE (SPECIFY) M.D.			Deputy			MEDICAL EXAMINER			DATE SIGNED 11-19-83														
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes			ADDRESS 900 Seton Dr. Cumberland, Md.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-22-83			23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cem.			23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.			COUNTY STATE 21802								
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.			25a. DATE REC'D. BY REGISTRAR NOV 23 1983			25b. REGISTRAR'S SIGNATURE John J. Coyle																				
BP _____			DHMH - 17 (VRA15 ME(5)) 15M 2/80																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from us as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

KIGHT FUNERAL HOME FOR 309 DECATOR STREET REGISTRAR CUMBERLAND, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28499				
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR				
MARTHA NAOMI PAYNE				OCTOBER 17, 1983				8:25 AM				
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				
Female		White		Month Day Year Aug. 10, 1923				If Under 1 Year If Under 24 hrs Months Days Hours Min.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Counselor				12b. KIND OF BUSINESS OR INDUSTRY SchoolSystem				
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 844 Greene St. 21502				
14. FATHER'S NAME FIRST Lloyd		MIDDLE E.		LAST Powers		15. MOTHER'S MAIDEN NAME FIRST Vesta		MIDDLE LAST Casto				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 235-30-0999		17. INFORMANT Chester G. Payne Cumberland, MD				ADDRESS 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL CELL CARCINOMA 1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(b) METASTASES OF CARCINOMA TO BRAIN DUE TO, OR AS A CONSEQUENCE OF SPINAL CORD, Bone, LUNGS. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
27d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
KENNETH ZEINKIEWICZ, M.D.		925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502		23d. LOCATION CITY OR TOWN		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 20, 1983		23c. NAME OF CEMETERY OR CREMATORY Bridgeport Cem.		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME William G. Kight Cumberland, MD		25a. DATE REC'D. BY REGISTRAR OCT 24 1983		25b. REGISTRAR'S SIGNATURE John G. Caniff								

WILSON LIBRARY HOME
ONE DECAYED SECRET
CIRCULATION NO. 5195

1983 NOV 17 1983 COLLEGE LIBRARY

00 1983 NOV 17 1983 COLLEGE LIBRARY

YESTERDAY ONLY

NOV 17 1983 CIRCULATION NO. 5195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8328500

1. DECEASED NAME (TYPE OR PRINT)	FIRST Jewell	MIDDLE Garnetta	LAST Peer	2a. DATE OF DEATH Nov. 17 1983	MONTH DAY YEAR	2b. HOUR 5:07 P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Feb. 10, 1924	DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 59	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cresaptown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corner Wilson & James Ave.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Textile			
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cresaptown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Corner Wilson & James Ave.		
14. FATHER'S NAME FIRST William	MIDDLE Henry	LAST Moyer	15. MOTHER'S MAIDEN NAME FIRST Sidna	MIDDLE Kyle	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-16-2980	17. INFORMANT Mrs. Jean Ogilvie, Horsham, Pa. Sister	ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____						
DUE TO, OR AS A CONSEQUENCE OF A Denocarcinoma of The Lung With METASTASES To The Brain						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET Dec 28 1982	CITY OR TOWN Present	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from Dec 28 1982 to Present , that (I) (we) last saw the deceased alive on Dec 28 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) died, (did not) view the body after death.)						
22b. SIGNATURE Ken Zienkiewicz M.D.						
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. DATE SIGNED 11-18-1983						
22e. ADDRESS 925 Bishop Walsh Road, Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 21, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Rocky Gap VA Cemetery	23d. LOCATION CITY OR TOWN Near Flintstone, Md.	COUNTY	STATE	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.	25a. DATE REC'D. BY REGISTRAR NOV 23 1983	25b. REGISTRAR'S SIGNATURE Dee. J. Cawieh				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR FROSTBURG, MD 21532				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							
				REG. NO. 28							
1. DECEASED NAME (TYPE OR PRINT)			FIRST VIOLA	MIDDLE MAY	LAST PERRY	20. DATE OF DEATH MONTH NOVEMBER DAY 23, YEAR 1983			2b. HOUR 10:45 AM		
3. SEX FEMALE			4. RACE WHITE		5. DATE OF BIRTH MONTH 12 DAY 29 YEAR 2006		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN 21532 FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS VALE SUMMIT ROAD RT. 3, BOX 197 21532	
14. FATHER'S NAME FIRST CHARLES			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST EDNA			MIDDLE	LAST	EASTON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b. SOCIAL SECURITY NO. N.A.		17. INFORMANT MR. JAMES PERRY, RT. 3, BOX 197,			FROSTBURG, MD. 21532			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Congestive Heart Failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 15 chronic Heart Disease			DUE TO, OR AS A CONSEQUENCE OF (b) 2 yrs								
(c)			DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov 20, 1983 , to Nov 23, 1983 , that (I) (we) last saw the deceased alive on NOV 23, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul Livengood MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-24-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL T. LIVENGOOD MD		22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/26/83		23c. NAME OF CEMETERY OR CREMATORIAL RESTLAWN MEM. GARD.		23d. LOCATION CITY OR TOWN LaVALE ALLEGANY MD.					
24. FURNITURE, ETC. None		25a. ADDRESS 60 W. MAIN ST.		25b. DATE REC'D. BY REGISTRAR DEC 01 1983		25b. REGISTRAR'S SIGNATURE John J. Conner					
26. FURNITURE, ETC. None		27. ADDRESS SOWERS FUNERAL HOME FROSTBURG									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 28											
1. FOR STATE REGISTRAR			1. DECEASED NAME FIRST JOHN MIDDLE FRANK LAST POLANTZ			2a. DATE OF DEATH MONTH NOVEMBER DAY 10, YEAR 1983			2b. HOUR 6 P.M.		
3. SEX MALE			4. RACE white			5. DATE OF BIRTH MONTH 16 DAY 22 YEAR 1918			6. AGE (IN YEARS LAST BIRTHDAY) 65		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION Retired Carpenter			12b. KIND OF BUSINESS OR INDUSTRY LOCAL 1024		
13a. STATE WVA			13b. COUNTY GRANT			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Antioch Rt, Box 84A 26743		
14. FATHER'S NAME FIRST FRANK MIDDLE MIDDLE LAST POLANTZ			15. MOTHER'S MAIDEN NAME ANNA			16. SOCIAL SECURITY NO. 232-09-0179			17. INFORMANT JUANITA POLANTZ ADDRESS NEW CREEK, WV 26743		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			18b. IMMEDIATE CAUSE (a) 1539			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approximately 15 months					
18d. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)			18e. DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-12 1983 to 11-10 1983, that (II) (we) last saw the deceased alive on 11-10 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE ANDREW STASKO M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-10-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW STASKO M.D.			22e. ADDRESS 924 Seton Drive, Cumberland, Md. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11-13-83			23c. NAME OF CEMETERY OR CREMATORIUM KNOBLEY Cemetery			23d. LOCATION CITY OR TOWN Antioch COUNTY Grant STATE WVA		
24. FUNERAL DIRECTOR NAME RENE S. SCHIFFER			ADDRESS 11 N Main St Petersburg WV 26841			25a. DATE REC'D. BY REGISTRAR NOV 14 1983			25b. REGISTRAR'S SIGNATURE John G. Lewis		

2307 117 7777001

1170000 1170000

11700

YANKEE YANKEE

ATTACK TACTIC

YANKEE

YANKEE

YANKEE

YANKEE

TACTIC

YANKEE

YANKEE YANKEE

YANKEE YANKEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified to the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 3 2 8 5 0 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST Edith	MIDDLE S	LAST Riffey	2a DATE OF DEATH MONTH 11-24-83	DAY	YEAR	2b HOUR 2128 M	
3. SEX female			4. RACE white		5. DATE OF BIRTH MONTH 07/02/906	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 77	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County			
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital DOA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cresaptown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12706 Valley View Drive				
14. FATHER'S NAME FIRST William			MIDDLE F	LAST Strawderman	15. MOTHER'S MAIDEN NAME FIRST Lelia	MIDDLE Fogle	LAST Strawderman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 74 4150		17. INFORMANT Melvin B. Riffey Sr. as above			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100			Cardiac Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction							
			DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1983 , to 11-24-83 , that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robustiano J. Barrena, Jr.		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 11-26-83					
22e. ADDRESS ROBUSTIANO J. BARRENA, JR. MEMORIAL HOSPITAL, CUMB., MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/28/83		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial		23d. LOCATION CITY OR TOWN Cumberland, Alleg., MD		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR NOV 29 1983		25b. REGISTRAR'S SIGNATURE John J. Hafer				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EICHORN FUNERAL HOME FOR STATE MAIN ST. REGISTRAR LONACONING, MD.			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						2 8 5 0 4				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
GEORGE MARSHALL ROBERTSON						NOVEMBER 28, 1983			9:58A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 5, 1918			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE COUNTRY Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.						
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Westvaco			12b. KIND OF BUSINESS OR INDUSTRY Paper		21539			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 67 State St., Lonaconing, Md.						
14. FATHER'S NAME Edward		MIDDLE — Robertson		15. MOTHER'S MAIDEN NAME Molly			16. ADDRESS Lonaconing, Md.		LAST Staup				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT 220-10-7498 Mrs. Mary Robertson			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory Failure			DUE TO, OR AS A CONSEQUENCE OF (b) COPD			10 yrs					
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.					DUE TO, OR AS A CONSEQUENCE OF (c) Lung Cancer complicating COPD			2 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 16.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above (if we did) (did not) view the body before death.		11/25 1983			83			11/28 1983		83			
22b. SIGNATURE Richard Schmitt, M.D.		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/183	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCHMITT, RICHARD M.D.					22e. ADDRESS DEPT. OF PULMONARY MEDICINE SACRED HEART HOSPITAL, CUMB. MD. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 30, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cem.			23d. LOCATION CITY OR TOWN Moscow		ONLY Allegany		Md		
24. FUNERAL DIRECTOR Eichorn Funeral Home, 8 E Main St, Lonaconing, Md.		ADDRESS Henry J. Eichorn			25a. DATE REC'D. BY REGISTRAR UEU 5 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1 - FOR STATE REGISTRAR			GEORGE-UPCHURCH FUNERAL HOME 202 GREENE STREET CUMBERLAND, MD 21502			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE			CERTIFICATE OF DEATH			28505				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN BURTON ROBINSON			LAST			7a. DATE OF DEATH NOVEMBER 6, 1983			MONTH	DAY	YEAR	2b. HOUR 4:15P M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH July DAY 8, YEAR 1927			6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH SACRED HEART HOSPITAL ALLEG MD.							
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed			12b. KIND OF BUSINESS OR INDUSTRY Carpenter							
13a. STATE Md.-21502			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 205 Davidson Street 21502				
14. FATHER'S NAME FIRST John MIDDLE Burt LAST Robinson			15. MOTHER'S MAIDEN NAME FIRST Dora MIDDLE - LAST Hager			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W.W.II			17. INFORMANT John E. Robinson			ADDRESS 207 East Street Frostburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5715 Endstage Corrosia															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF			(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from November 1, 1983, to November 6, 1983, that (I) (we) last saw the deceased alive on November 6, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE GARY L. WAGONER, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-7-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY L. WAGONER, M.D.			22e. ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/8/83			23c. NAME OF CEMETERY OR CREMATORIAL Rocky Gap Vet. Cem.			23d. LOCATION CITY OR TOWN Cumberland-Allegany Co.-Md.			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME George Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland						25a. DATE REC'D. BY REGISTRAR NOV 14 1983			25b. REGISTRAR'S SIGNATURE John Canfield							

CELESTINE HARRIS



CELESTINE HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8528506	
					REG. NO.	
1 - STATE REGISTRAR						
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Francis H. Ruge					November 29, 1983	6 P.M.
1. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS	
Male		White	January 15, 1901		79	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland		U.S.A.				Allegany
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Frostburg		260 E. Main St.			Game Warden	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS
Maryland		Allegany	Frostburg			260 E. Main St.
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE
Robert		J.	Ruge	Frances		Schreiber
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
No		213-09-6510		Miss Ann Ruge, Frostburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) 4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Coronary occlusion — a.s.c.v.i.d. — — sudden				
DUE TO, OR AS A CONSEQUENCE OF (b) —		— a.s.c.v.i.d. —				
DUE TO, OR AS A CONSEQUENCE OF (c) —		C.O.P.D. —				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Emphysema</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE
22a. I certify that (I) (we) attended the deceased from 6-10-82, 19 —, to 11-28, 19 83, that (I) (we) last saw the deceased alive on 11-28, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>H.C. Diehl M.D.</i>		DEGREE		22c. DATE SIGNED 11-30-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. C. Diehl		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 95 E. Main St. Frostburg, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/2/83	23c. NAME OF CEMETERY OR CREMATORIAL St. Michaels		23d. LOCATION CITY OR TOWN Frostburg Allegany Md.	
24. FUNERAL DIRECTOR NAME Durst Funeral Home		57 Frost Ave. Frostburg, Md.		25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>



NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

SCARPELLI FUNERAL HOME FOR STATE REGISTRAR 108 VA. AVE. CUMBERLAND, MD. 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 28501					
1. DECEASED NAME (TYPE OR PRINT)				LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
JOHN HOWARD SEEDERS								NOVEMBER 13, 1983				9:50P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH Oct. 26, 1918 DAY YEAR		65		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		USA						ALLEGANY COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL				Retired Conductor				Railroad			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE					
13a. STATE W. Va.	13b. COUNTY Mineral	13c. CITY OR TOWN Ridgeley						Route 1, Box 574					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John Frank Seeders				Delcie Baker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS					
Yes		War II		705-12-6574				Mrs. Mabel Seeders, Ridgeley, W. Va. Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronaromatosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenosarcinoma of Colon</u> (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 13 1983</u> , to <u>Nov 13 1983</u> , that (I) (we) lost saw the deceased alive on <u>Nov 13 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)													
WAYNE SPIGGLE, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-17-1983		23c. NAME OF CEMETERY OR CREMATORIAL Restlwan Mem. Gardens		23d. LOCATION CITY OR TOWN La Vale, Allegany, Md.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR 21-883				25b. REGISTRAR'S SIGNATURE Jean J. Scarpelli					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILE. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												28508		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
Jean					Shearer	<input type="checkbox"/> IF UNDER 1 YR. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS			<input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.			X 11-6 1983		
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR					
F		Cau	Oct. 1, 1894		89	<input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			11-6 1983		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md			USA			<input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Allegany		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Midland			Rt box 499A Frostberg Md						Homemaker			Own Home		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Md			Allegany		Midland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Bans Rock Rd. 21542					
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME FIRST			WYPER					
Robert Izzett			LAST			Janet			WYPER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			None			214-01-6237			Mrs. Jean Lancaster, 499A, Frostburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>												Sudden		
DUE TO, OR AS A CONSEQUENCE OF														
{ (b) <u>Cerebral vascular accident</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Ast. Dpty MEDICAL EXAMINER										DATE SIGNED		
EXAMINER'S NAME (TYPE OR PRINT)		Paul Snow, M.D.										11-6-83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial		Nov. 9, 1983		Frostburg Mem. Park			Frostburg			Allegany		Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
John J. Casper		Baltimore Funeral Home, Lonaconing, Md.		NOV 9 1983			John J. Casper							

Final budget for 1966-1967

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WHILE THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

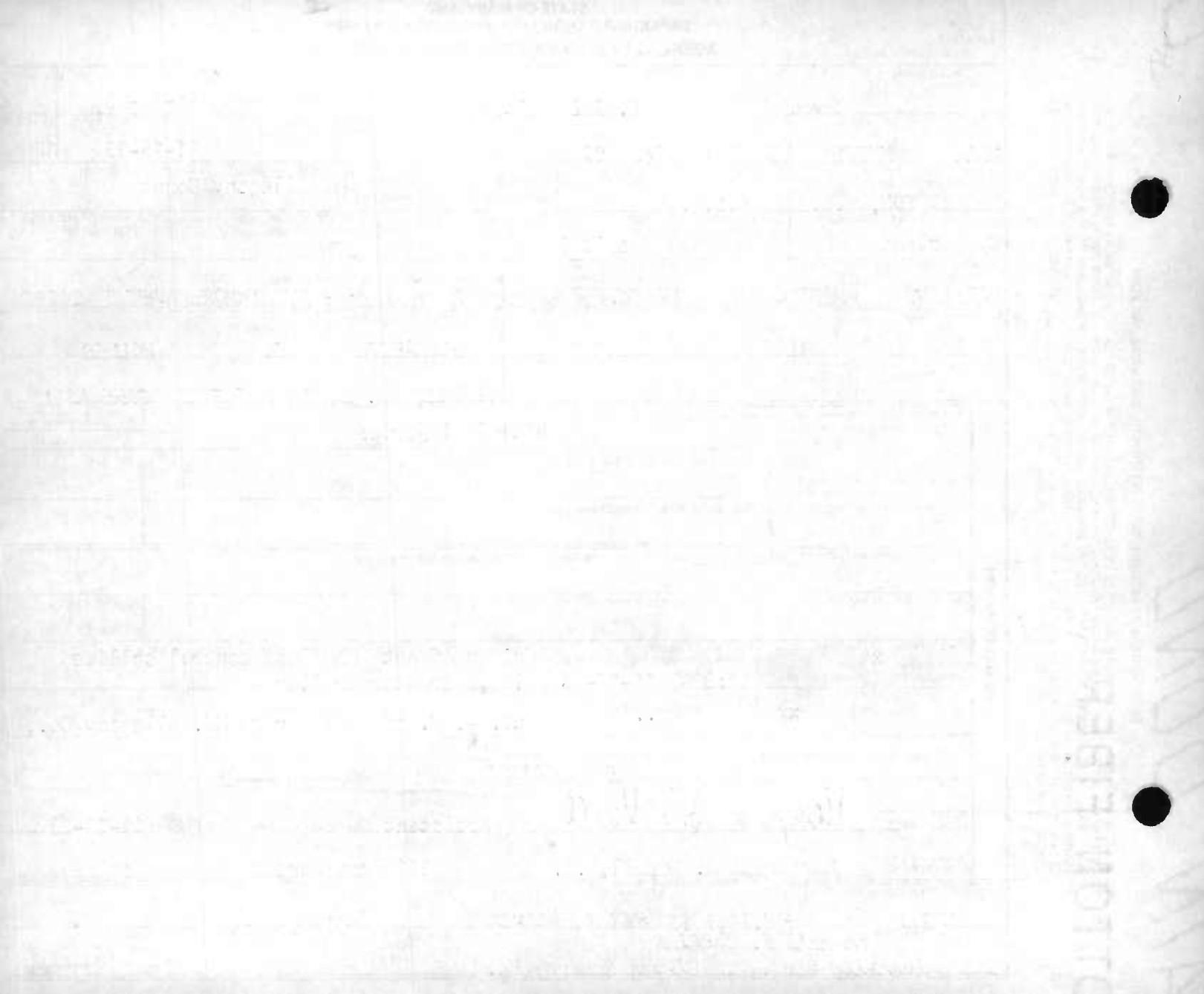
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28509

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	XX	MONTH	DAY	YEAR	2b. HOUR	
			MARK	DANIEL	SHERMAN	11-15-83						
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR. MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	11-15-83	MONTH	DAY	YEAR	2d. HOUR	
MALE	WHITE	APRIL 12 1962	21 yrs.								1PM M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County					
WASHINGTON, D.C.		U.S.A.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland		Memorial Hospital			STUDENT							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		13f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
14. STATE MARYLAND		14. COUNTY MONTGOMERY		GARRETT PARK		4606 STRATHMORE AVENUE 20896						
15. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
FRANCIS		WILLIAM		SHERMAN		ELIZABETH		E.		HOLMES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Multiple injuries			
NO					FRANCIS WM. SHERMAN		FATHER		SAME AS 13			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30AM 11-15-83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) driver of auto who lost control/collided with a tractor trailer							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.			21f. LOCATION STREET Rt. 40 W. of Belle Grove Md.		CITY OR TOWN Allegany Co., Md.		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) M.D. Assistant			22c. MEDICAL EXAMINER							
ACTUAL SIGNATURE <i>Margie A. Korell</i>												
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.			ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE NOV. 18, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION CITY OR TOWN Silver Spring		COUNTY Mont		STATE Md.	
24. FUNERAL DIRECTOR NAME		Francis J. Collins			25a. DATE REC'D. BY REGISTRAR NOV 21 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conley</i>					
BP _____		500 University Blvd., W. Silver Spring, Md.										
DHMH - 17 (VR A15 ME (5)) 20M 4/82												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from us or the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "None", Item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 28510				
										REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
(TYPE OR PRINT)			11-22-83							9:20 AM				
1. DECEASED NAME FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR							6. AGE (IN YEARS LAST BIRTHDAY)				
Floyd L. Short			Sept. 17, 1910							73 YRS.				
3. SEX			4. RACE			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				10. CITY OR TOWN OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH		
Male			White							West Virginia		Allegany MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
West Virginia			USA			Cumberland Nursing Home				Retired Mechanist		Railroad		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland			Allegany			Cumberland					718 Shawnee Ave. 27502			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Albert L. Short			Nannie B. Marker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT				ADDRESS				
No			705-12-4606			Miss Gladys & Margaret Short, Cumberland, Md.				Sisters				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5990 Gram Negative Septicemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) Severe urin infection														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Organic Brain syndrome 20% cerebral arteriosclerosis.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9-10 1981 to 11-21 1983, that (I) (we) last saw the deceased alive on above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED				
22b. SIGNATURE N.P. SAHETA MD										22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) N.P. SAHETA										22f. ADDRESS Memorial Hosp., Cumberland Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-25-1983			23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK				23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.		COUNTY STATE		
24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.										25a. DATE REC'D. BY REGISTRAR DEC 01 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR			HAFER FUNERAL HOME 1302 NATIONAL HIGHWAY LAVAL, MD 21502						STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 28512		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR			21b. HOUR			
LAURA BELLE SMITH									NOVEMBER 25, 1983			6:05A M			
SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 07 DAY 19 YEAR 01			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD								
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home								
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Mt. Savage			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 108 Foundry Row 21545					
14. FATHER'S NAME FIRST Jesse		MIDDLE		LAST Fletcher			15. MOTHER'S MAIDEN NAME Ida			16. ADDRESS 512 B Street					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-8710		17. INFORMANT Mrs. Pearl Biggs			18. CAUSE OF DEATH (Enter only one cause per item 18, PART 1 & PART 2) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Arteric stenosis			APPROXIMATE DATE OF DEATH/INTERVAL FROM ANOTHER DEATH 3 days 3 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) Nov 25 1983		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Nov 23, 1983, to Nov 25, 1983, that (I) (we) last saw the deceased alive on Nov 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Chang Oh, M.D.		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532			22f. DATE SIGNED Nov 25-83					
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial		23b. DATE 11/28/83		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Savage Meth.			23d. LOCATION CITY OR TOWN Mt. Savage, Alleg., MD								
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR NOV 29 1983			25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr.								
DHMH - 16 50M 4/83 (VRA 15, 4)															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a signature of the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trust seal. Then please remove carbon paper. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT!) If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

202 GREEN STREET
FOR 202 GREEN STREET
1 - STATE REGISTRAR CUMBERLAND, MD 21502

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

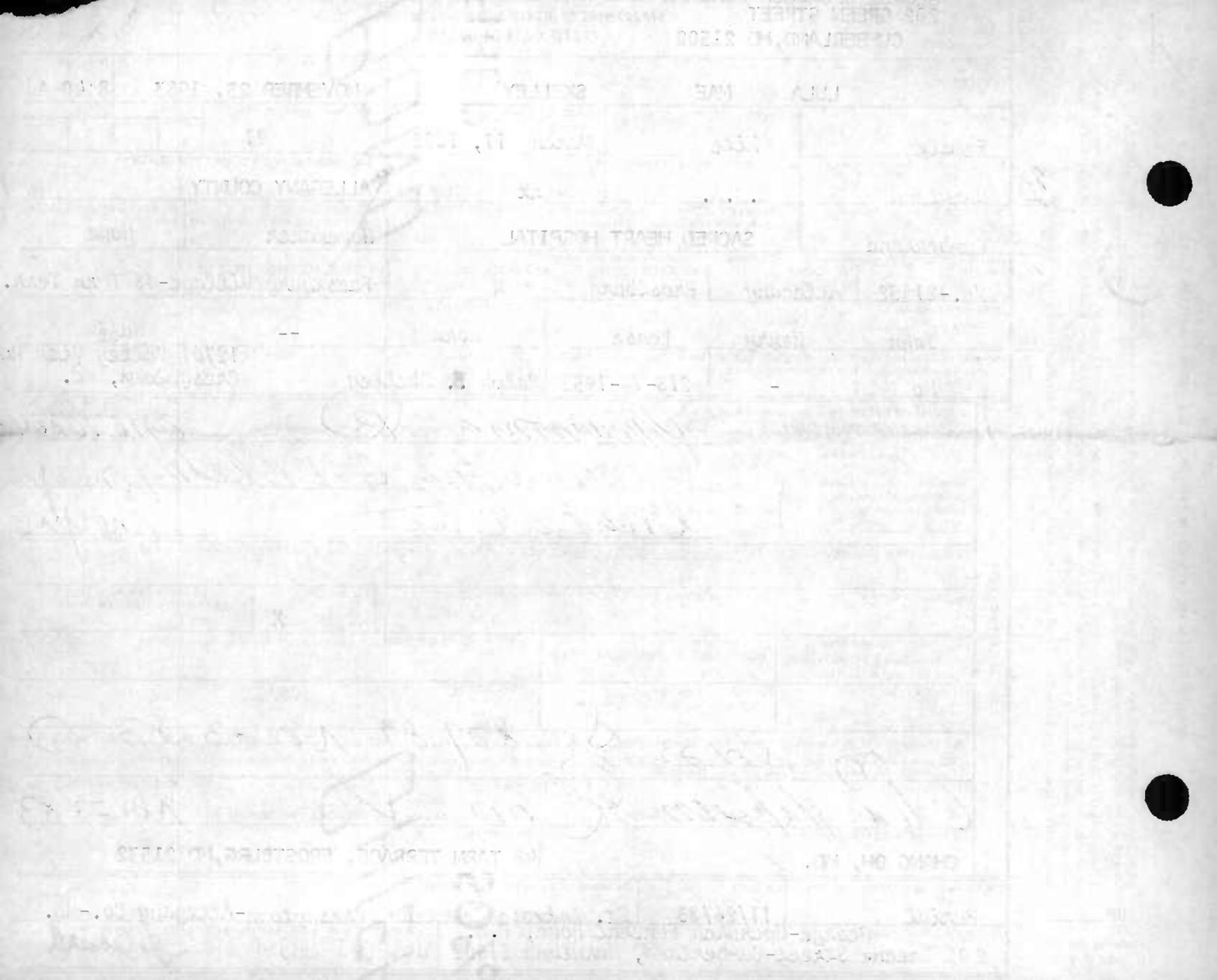
REG. NO. 2851

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	26. DATE OF DEATH	MONTH	DAY	YEAR	28. HOUR
			LULA	MAE	SKELLEY	NOVEMBER 23, 1983			8:40 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR	
Female		White		March 11, 1892		91 yrs			MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland		U.S.A.				ALLEGANY COUNTY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL		Homemaker			Home			
13. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Md. - 21532		Allegany		Frostburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Frostburg Village-48 Tarn Terr. 21532	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS			
John		Henry		Lease	Nora		12701 Valley View Rd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					Cresaptown, Md.	
No		213-74-1953		Ralph B. Skelley						
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and item 19.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <input checked="" type="checkbox"/> ONE WEEK 5621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Skin infection from G-E Bleeding for one year</i> (c) <i>Urinary tractitis</i> ONE YEAR										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 OR PART 21)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET		CITY OR TOWN:	COUNTY:	STATE:		
22a. I certify that (I) (this hospital) attended the deceased from Nov 22, 1982 to Nov 23, 1983, that (I) (we) last saw the deceased alive on Nov 22, 1982 and that in my/our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. DEGREE			22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED Nov 23-83		
22e. SIGNATURE <i>Chang Oh, MD.</i>										
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS			22h. ADDRESS			22i. DATE SIGNED		
CHANG OH, MD.		48 TARN TERRACE, FROSTBURG, MD 21532						Nov 23-83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY	23f. STATE
Burial		11/26/83		St. Ambrose Cemetery			Cresaptown-Allegany Co.-Md.			
24. FUNERAL DIRECTOR NAME		George Upchurch Funeral Home, P.A.		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
202 Greene Street-Cumberland, Maryland 21502							UTC 01 1983		<i>John J. Connelly</i>	

28. Autopsy after death. Page 4 may be continued with 28a.

29. Autopsy after death. Page 4 may be continued with 29a.

BP _____
DHMH - 16 50M 4/83
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be fed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					83 28 51 3
					REG. NO.
1 - FOR STATE REGISTRAR		2d DATE OF DEATH			MONTH DAY YEAR
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. HOUR
George Wellington Stair					11/03/83 6:08a.m.
3. SEX		4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White	MONTH DAY YEAR	IF UNDER 1 YEAR	IF UNDER 24 HRS.
			4/27/11	72	MONTHS DAYS HOURS MIN.
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8	9 BALTIMORE CITY OR COUNTY OF DEATH	
Pa.		USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Allegany MD.	
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Cumberland		Sacred Heart Hospital			Farmer
13a. STATE Pa.		13c. CITY OR TOWN Bedford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Box 98, R D 1 / 15545	
14. FATHER'S NAME FIRST John		MIDDLE W. Stair	15. MOTHER'S MAIDEN NAME FIRST Ella Blanche Kinton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214 07 5232	17. INFORMANT Avalene G. Stair, Bx98, R D 1, Hyndman, Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292		C. H. F & pulmonary edema ASCVD - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) lost saw the deceased alive on 10-26 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Uriel E. Velandia</i>		DEGREE <i>MD</i>		22c. DATE SIGNED 11-3-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Uriel E. Velandia		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/6/83	23c. NAME OF CEMETERY OR CREMATORIAL Hyndman Cemetery	23d. LOCATION CITY OR TOWN Hyndman, Bedford Cty, Pa.	
24. FUNERAL DIRECTOR NAME Harvey H. Zeigler, Hyndman, Pa.		ADDRESS	25a. DATE REC'D. BY REGISTRAR NOV 7 1983	25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>	

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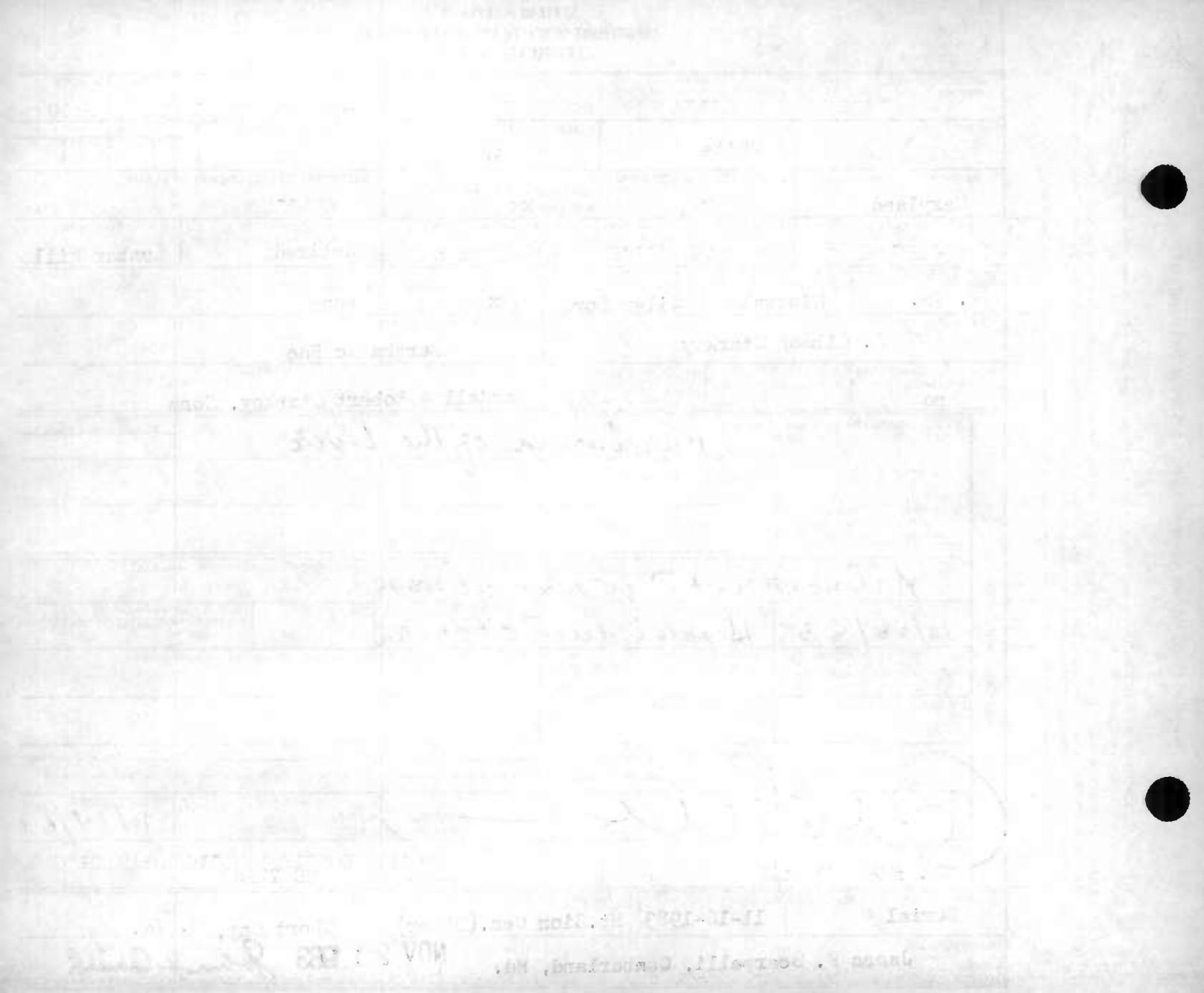
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 28514				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			RANDALL WILLIAM STARKEY						NOVEMBER 13, 1983			8:30 PM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH 7 DAY 16 YEAR 1909			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
MALE			White											
7b. CITIZEN OF WHAT COUNTRY?			USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Lumber Mill					
CUMBERLAND			MEMORIAL HOSPITAL & MEDICAL CENTER											
13a. STATE W. Va.			13b. COUNTY Mineral			13c. CITY OR TOWN Wiley Ford			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS none 99999		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
J. Gibson Starkey			Bertha Mc Bee											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
no			214-07-4484			Randall & Robert Starkey, Sons								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Liver.</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1550 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arterio sclerotic heart disease.</i>														
19a. DATE OF OPERATION 10/28/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Hepatic duct obstruction</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>John J. Allen</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/14/83					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. AMADO TORRES			22f. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-16-1983			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cem. (Biser)			23d. LOCATION CITY OR TOWN Short Gap, W. Va.			COUNTY STATE		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.			ADDRESS			NOV 21 1983			DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE <i>John J. Allen</i>		

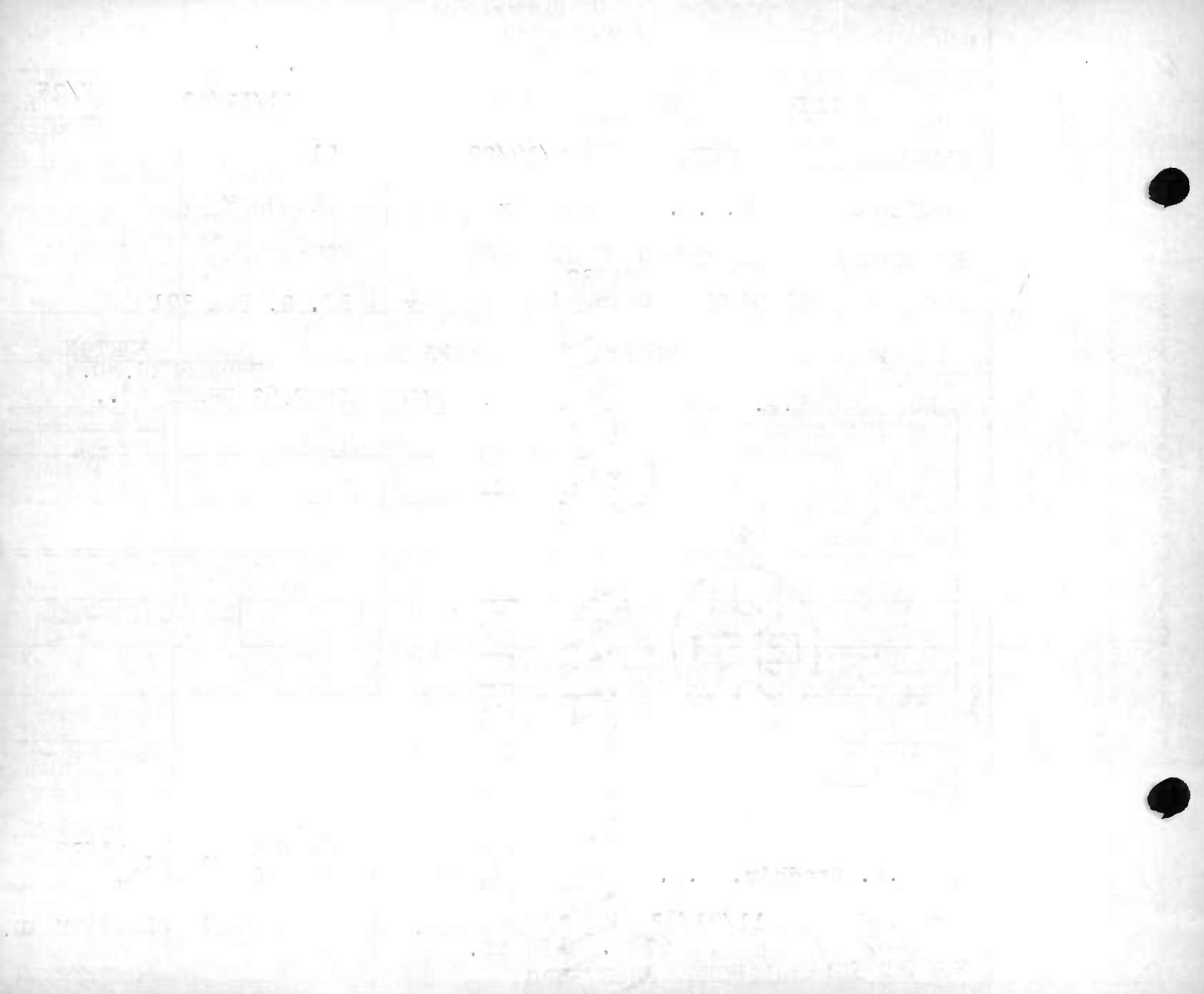


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 must be detached for use at the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28515		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 11/19/83									2b. HOUR 5/25 AM		
1. DECEASED NAME (TYPE OR PRINT) NELLIE MAE STOTT			4. RACE WHITE			5. DATE OF BIRTH MONTH 2/17/92 DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
3. SEX FEMALE			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FROSTBURG NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			MD. 21532		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RT. 2, BOX 371		
14. FATHER'S NAME FIRST GEORGE			MIDDLE PORTER			15. MOTHER'S MAIDEN NAME FIRST EMMA			MIDDLE			LAST BURTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N.A.			17. INFORMANT MR. LAYTON STOTT, 83 GRANT ST.,			ADDRESS FROSTBURG, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Possible Pneumonia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Parkinson Disease- old age- Ca left Breast														
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/17/83 to 11/19/83, that (I) (we) last saw the deceased alive on 11/17/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 11/21/83		
22b. SIGNATURE S. L. Snadhir, M.D.			22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. L. Snadhir, M.D.			22e. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			FROSTBURG, MD. 21532		
23a. BURIAL, CREMATION, REMOVAL (SPECIFIED) BURIAL			23b. DATE 11/21/83			23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM. PK			23d. LOCATION CITY OR TOWN FROSTBURG			COUNTY ALLEGANY	STATE MD.	
24. FUNERAL DIRECTOR M. Sowers 60 W. MAIN ST. SOWERS FUNERAL HOME FROSTBURG			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 23 1983			25b. REGISTRAR'S SIGNATURE John J. Conner					

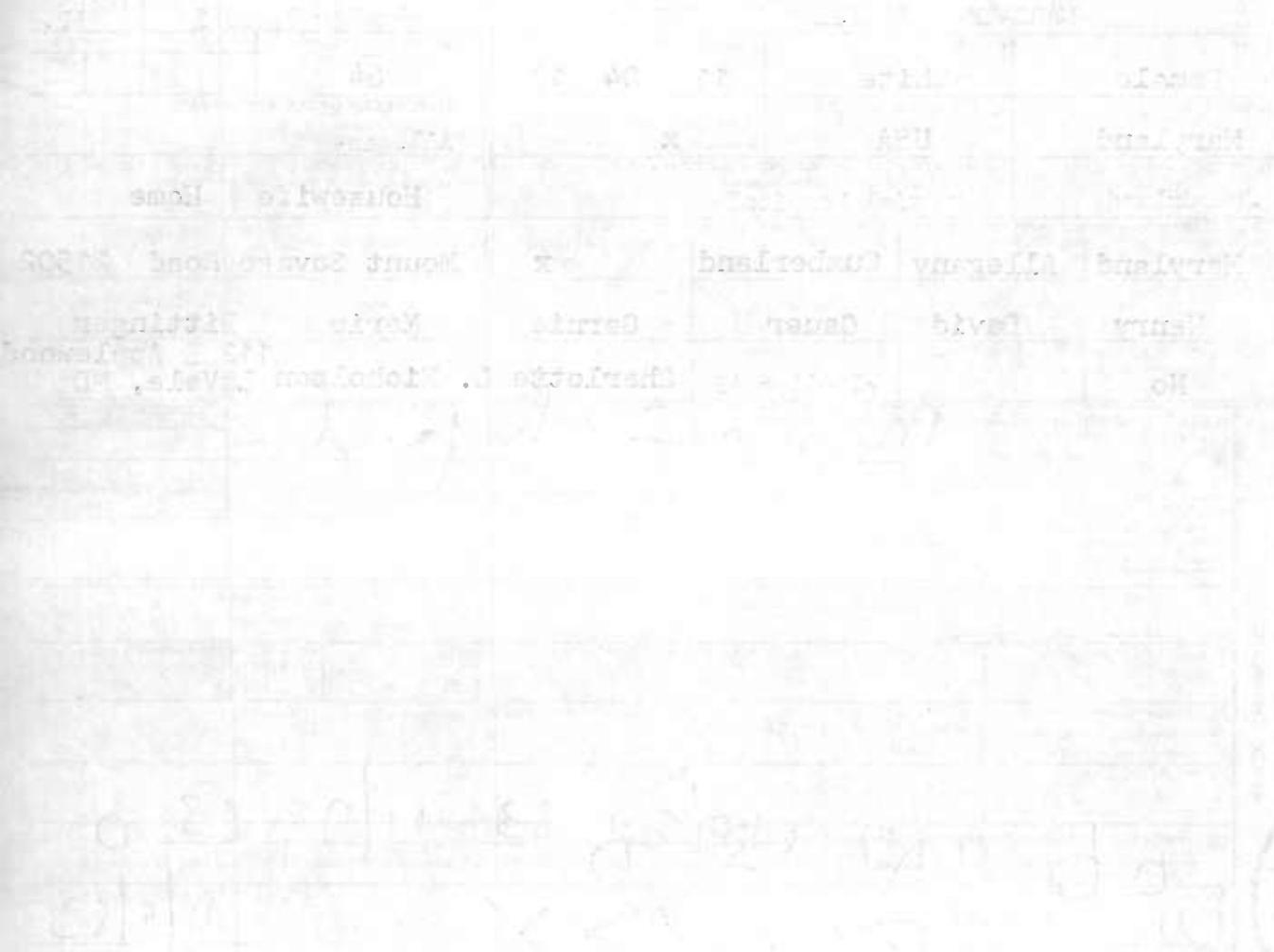


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to Burial, Cremation, or Removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be certified at time of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 5 2 8 5 1 6								
1. FOR STATE REGISTRAR			2. DATE OF DEATH November 7, 1983							26. HOUR 10:35 P.M.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MARGARET	MIDDLE LOUISE	LAST TAYLOR	28. DATE OF DEATH MONTH DAY YEAR												
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 04 YEAR 19			6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.										
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital							12d. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Mount Savage Road 21502							
14. FATHER'S NAME FIRST Henry			MIDDLE David		LAST Gauer			15. MOTHER'S MAIDEN NAME FIRST Garnie			MIDDLE Marie		LAST Bittinger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-14-6015							17. INFORMANT Charlotte L. Nicholson LaVale, MD			ADDRESS 112 D Applewood LaVale, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN CASE AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION													19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY							
21g. I certify that (I) (this hospital) attended the deceased from <i>1983 Nov 29</i> , to <i>1983 Nov 30</i> . That (I) (we) last saw the deceased alive on <i>1983 Nov 29</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													21h. DATE SIGNED <i>11/9/83</i>					
22a. SIGNATURE <i>B. Barrera</i>			22b. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																		
Dr. Robustiano Barrera																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/10/83			23c. NAME OF CEMETERY OR CEMETARY Rest Lawn Mem.			23d. LOCATION CITY OR TOWN LaVale, Allegany, MD			23e. COUNTY STATE						
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.			ADDRESS LaVale, MD			25a. DATE REG'D MARY. REG. DEPT. NOV 14 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>									



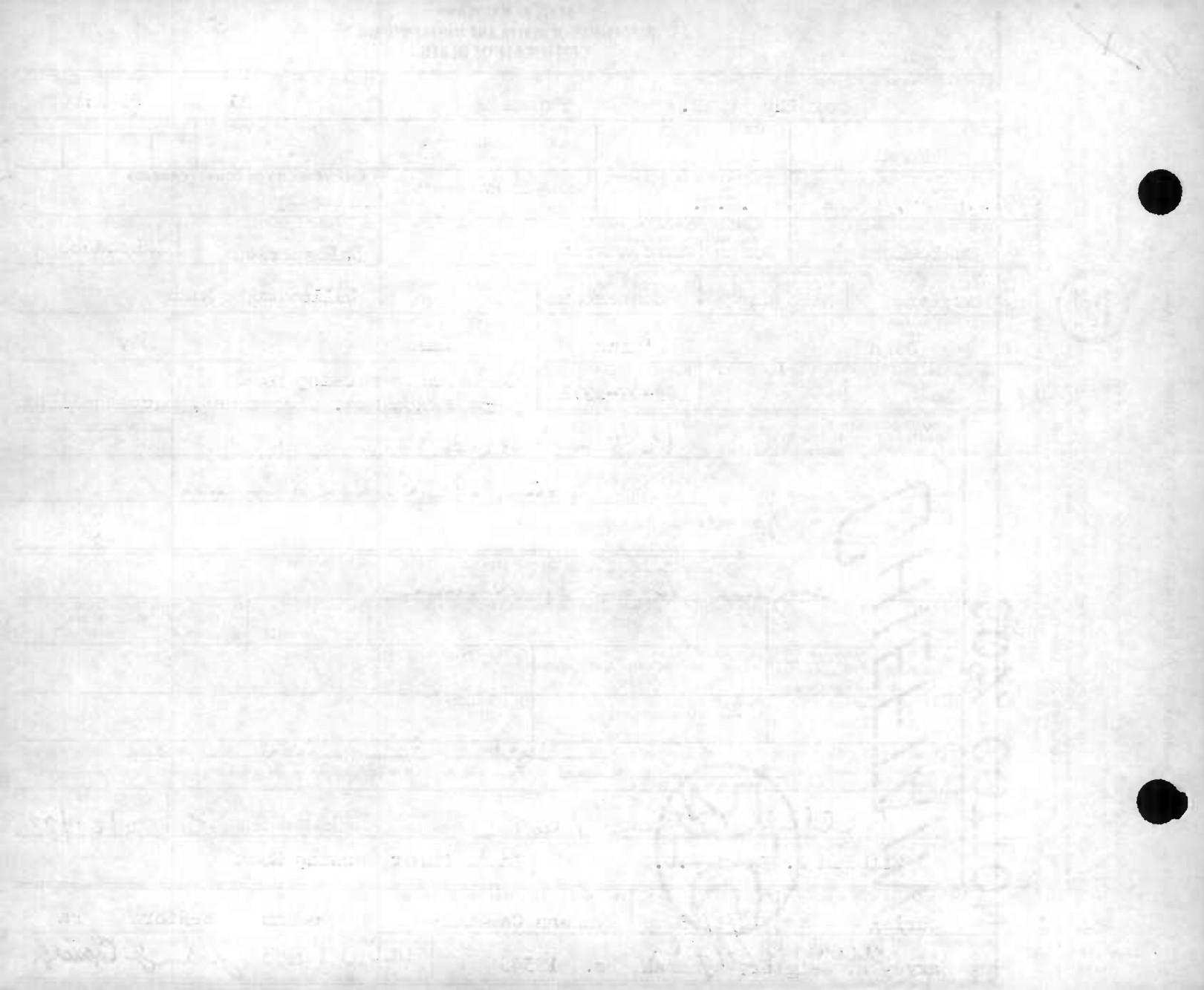
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 through 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28511			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Dorothy E. Thomas						11	26	83	1:00P	M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			Caus			05	16	05	78			MONTHS	DAYS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Hyndman, Penna			U.S.A.						Allegany			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cumberland			Lions Manor Nursing Home			Salesperson			Insurance						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland		Allegany		Cumberland					Willowbrook Road			21502			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
			John		O'Roke				Emma		May				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			169-07-5371			Lions Manor Nursing Home			Seton Drive Ext. Cumberland, Maryland 21502						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u>															
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) <u>Acute Allergosensitiv Head Rashes</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Angione Brain Anoxia</u>															
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1983</u> , to <u>Dec 1983</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>William P. James M.D.</u>						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>4/27/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Lions Manor Nursing Home									
William P. James M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Burial			12/1/83			Hyndman Cemetery			Hyndman			Bedford	Pa		
24. FUNERAL DIRECTOR NAME <u>Harvey H. Zeigler</u> ADDRESS <u>Hyndman, Pa. 15545</u>						25a. DATE REC'D. BY REGISTRAR <u>DEC 01 1983</u>			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>						

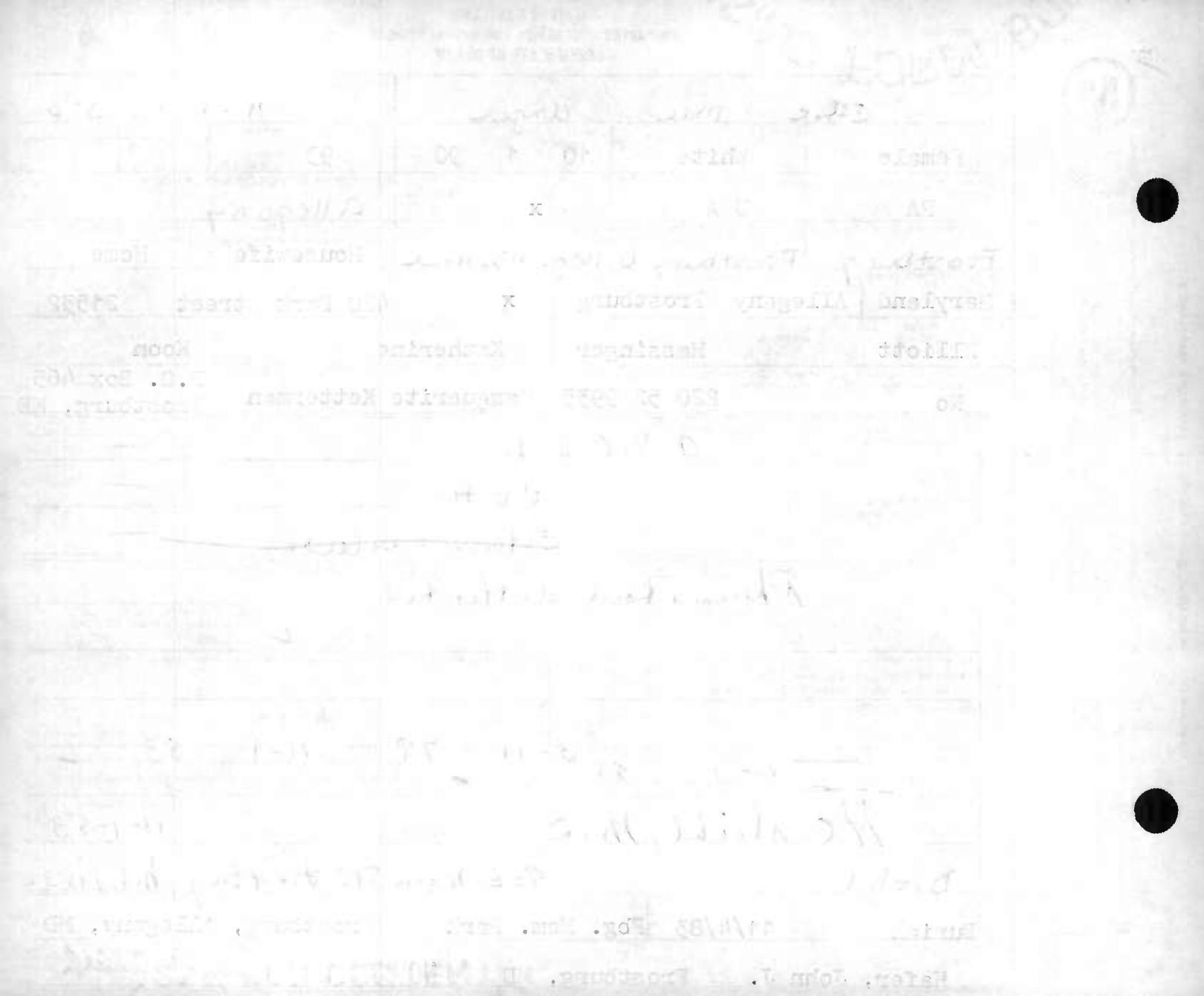


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 83 28518	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Coffie Mae Unger</i>						11 - 1 - 83				3:50 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		10 ^{MONTH} 1 ^{DAY} 90 ^{YEAR}		93		YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
PA		USA				Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Frostburg		Frostburg Village Nursing Home		Housewife		Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Allegany		Frostburg		YES <input checked="" type="checkbox"/>		420 Park Street		21532			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Elliott				Hassinger		Katherine				Koon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		P.O. Box 465					
No		220 52 9935		Marguerite Ketterman				Frostburg, MD					
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>a.s.c.v.d.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF C.V.A.												—	
DUE TO, OR AS A CONSEQUENCE OF (c) _____ <i>asthma - asthma</i>												—	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pneumonia</i>												—	
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) <input type="checkbox"/> above hospital attended the deceased from <i>5-11-79</i> to <i>11-1-83</i> , that (I) <input type="checkbox"/> last saw the deceased alive on <i>11-1-83</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not <input type="checkbox"/> view the body after death.													
22b. SIGNATURE <i>H.C. Diehl, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-1-83</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Diehl</i>		22e. ADDRESS <i>95E. Main St Frostburg, Md. 21532</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/4/83		23c. NAME OF CEMETERY OR CREMATORIAL Fog. Mem. Park		23d. LOCATION CITY OR TOWN Frostburg, Allegany, MD		25a. COUNTY STATE					
24. FUNERAL DIRECTOR NAME Hafer, John J.		ADDRESS Frostburg, MD		25b. DATE REC'D. BY REGISTRAR NOV 7 1983		25c. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8519

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)						FIRST Pauline	MIDDLE MABEL	LAST VALENTINE	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH 11	DAY 1	YEAR 83	2b. HOUR 407 P.M.
3. SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 3, 1913	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD 11-1 19 83	MONTH 11	DAY 19	YEAR 83	2d. HOUR 4 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 430 Warwick Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Cashier		12b. KIND OF BUSINESS OR INDUSTRY Drug Co.			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 430 Warwick Avenue		21503			
14. FATHER'S NAME FIRST Willis		MIDDLE Messick		LAST		15. MOTHER'S MAIDEN NAME FIRST Ethel		MIDDLE Grayson		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-07-4851		17. INFORMANT Mrs. William L. Valentine, Cumberland, Md.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) Arteriolosclerotic Heart Disease (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Carcinomatosis													
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Nicholas Giarritta, M.D.</i> TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER												DATE SIGNED 11-1-83	
EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S ADDRESS 900 Seton Dr; Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-5-1983		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 7 1983		25b. REGISTRAR'S SIGNATURE <i>John C. Conroy</i>							

5-11

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of the following

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of the following

of the following

infection, antibiotic, antibiotic

1000

example, small, antibiotic, antibiotic

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of the following

of the following

and find out what you

information about the following

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												28520		
												REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			AUSTIN Lloyd WARNICK						November 13, 1983			7:24 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		Nov 14 1907			75 YRS.			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		U.S.A.					Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Memorial Hospital & Medical Center		Retired Employee			Fire Dept			21502				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Allegany		Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1012 Frederick Street				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
William P Warnick, Sr		Mary												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
No		705-07-9753		Mrs. Martha Warnick			1012 Frederick Street			Cumberland, Md 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4110</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Prolonged Acute Coronary insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Chronic obstructive pulm. disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Severe Chronic obstructive pulm. disease</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>11/13/83</i> , to <i>11/13/83</i> , that (I) (we) last saw the deceased alive on <i>11/13/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED		
22b. SIGNATURE <i>Sheau Nathan</i>		22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sahn Nathan		22f. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 16, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Sunset memorial Park			23d. LOCATION CITY OR TOWN Cumberland Allegany Maryland							
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service		ADDRESS 404 Decatur St Cumberland, Md			25a. DATE REC'D. BY REGISTRAR NOV 17 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>						

M



Wardens - Oct 84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

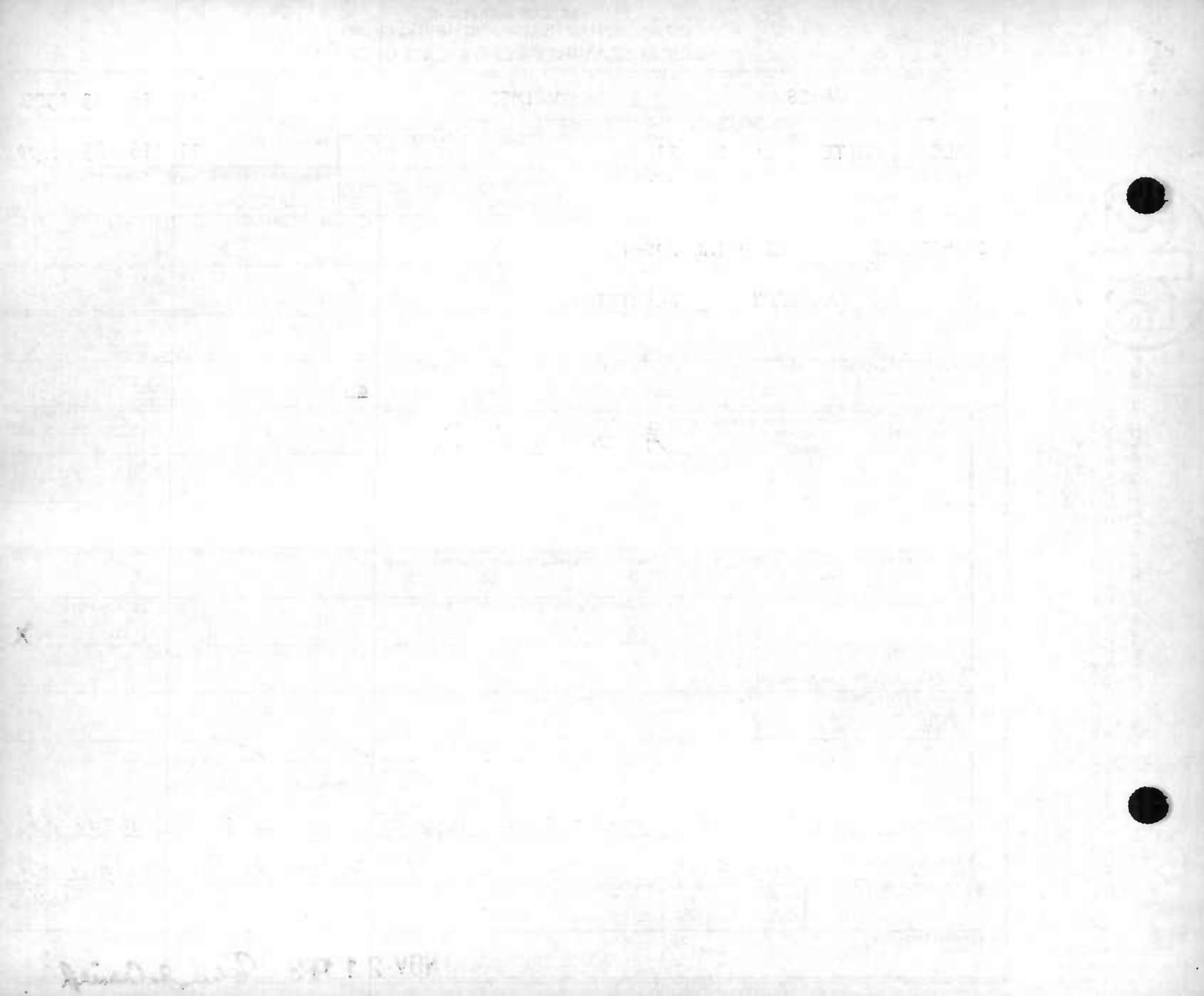
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28521				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Pearl Malinda Watkins						11/21/83			10:50PM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
female		white		9 19/ 99			84 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
PA		USA					Allegany Co							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Frostburg, MD		Frostburg Community Hospital								Housewife				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
MD		Allegany		Frostburg						Route 2, Box 65 21532				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME										
Wilbur				Ida										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No				220 58 1100			Ira R. Watkins - same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Recurrent Pneumonia (R) one week				
DUE TO, OR AS A CONSEQUENCE OF (b) Massive Cerebral infarction one month														
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease c. A. fib.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) this hospital attended the deceased from Oct 25, 1983, to Nov 21, 1983, that (II) (we) last saw the deceased alive on Nov 21, 1983, and that (III) (my) our opinion death occurred on the date and hour and from the causes stated above. (IV) we did not view the body after death.														
22b. SIGNATURE DEGREE Charlynn C. Oh										22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C. Oh										22e. ADDRESS 48 Tarn Terrace, Frostburg, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE 11/25/83			23c. NAME OF CEMETERY OR CREMATORY St. John's			23d. LOCATION CITY OR TOWN Greenville Somerset, PA COUNTY STATE					
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr. ADDRESS LaVale, MD										25a. DATE REC'D. BY REGISTRAR NOV 28 1983 25b. REGISTRAR'S SIGNATURE				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.

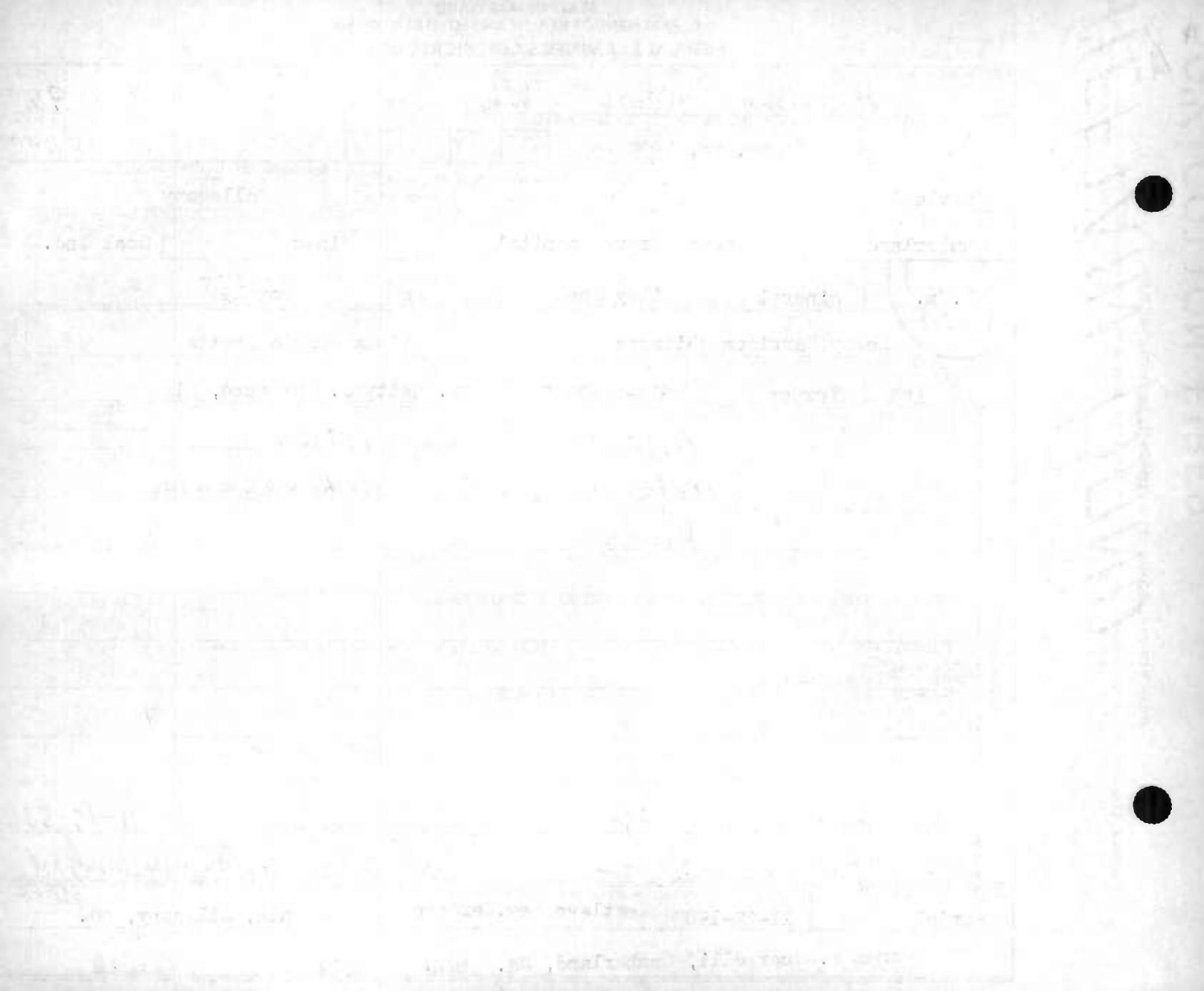
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
28522 REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	
JAMES			VINCENT	WEIMER		<input type="checkbox"/>	11	16	1983	1300	M	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR
MALE		WHITE	04 25 21	62			<input type="checkbox"/>	11	16	1983	1300	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		USA			<input type="checkbox"/> DIVORCED			ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			MEMORIAL HOSPITAL					RETIRED CHESSIE SYSTEM RAILROAD			35	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		ADDRESS		
MD		ALLEGANY		FLINTSTONE				STAR ROUTE		21530		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	CROWE		
SAMUEL				WEIMER	DELA					21530		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII			17. INFORMANT			ADDRESS			
			214-16-2609			AMANDA WEIMER STAR ROUTE FLINTSTONE MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. S. C. V. D.</u> DUE TO, OR AS A CONSEQUENCE OF 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		Francisco Reyes		M.D.		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		Francisco Reyes		ADDRESS		900 Senton Dr. Cumberland, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		
BURIAL		NOV 19 1983		REST LAWN CEMETERY			LAVALE ALLEGANY MARYLAND			21502		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND				NOV 21 1983			Reverend Carl					
DHMH-17 (VR A15 ME (5)) 15M 2/80												



M
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3 RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 28523	
1- STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			2b. MONTH DAY YEAR			2b. HOUR	
			<i>Harrison Kemp Whitacre</i>			<input checked="" type="checkbox"/> 11 19 1983			11 19 1983			9:59 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	
M		W		Aug. 28, 1930		53 yrs.						11 19 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
Maryland		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		Sacred Heart Hospital						Miner			Coal Ind.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
W.Va.		Mineral		Wiley Ford		YES <input type="checkbox"/>		Box 196					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Dewey Harrison Whitacre		Viola Sophia Knotts											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO, OR UNKNOWN]		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes Korean		215-26-7113		Mrs. Betty J. Whitacre, Wife									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DOUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Arteriosclerotic Cardiovascular</i> DOUE TO, OR AS A CONSEQUENCE OF (c) <i>Disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		<i>Francisco Reyes</i> M.D. Deputy MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) ADDRESS 900 Seton Dr. Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			DATE SIGNED 11-19-83			
Burial		11-22-1983		Restlawn Mem. Gardens			La Vale, Allegany, Md.			21502			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
James F. Scarpelli		Cumberland, Md.		NOV 23 1983			Dee J. Casper						
DHHM-17 (VR A15 ME (5)) 15M 2/80													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 83 28524													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Randall D. Wilburn						11			10	83		9:05 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH	DAY	YEAR	59			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County						
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Air Condition			12b. KIND OF BUSINESS OR INDUSTRY Textile					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 50 W. Mechanic St. 21532					
14. FATHER'S NAME FIRST Norman		MIDDLE Wilburn		LAST		15. MOTHER'S MAIDEN NAME FIRST Hazel		MIDDLE Custer			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Yes W.W. 2		16c. DATE OF OPERATION		17. INFORMANT		ADDRESS					
		218-12-5480				D. Nolan		48 Tarn Terrace	Frostburg, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Inflammation to Brain</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 1629 4 83		CITY OR TOWN N.Y. 10 83		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1983 to 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <i>Chang H. Oh, MD</i>		DEGREE MD		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED NOV 17 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chang H. Oh, MD		22e. ADDRESS 48 Tarn Terrace Frostburg, MD 21532											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 14, '83		23c. NAME OF CEMETERY OR CREMATORIAL Grantsville Cemetery		23d. LOCATION CITY OR TOWN Grantsville, Md.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 17 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Cawieh</i>							

Leucostethus (4) *viridis* (Gmelin) *var. flavolineatus* (Hartweg)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2852
1- STATE REGISTRAR		1. DECEASED NAME FIRST JOHN FRANKLIN MIDDLE WILLINGHAM LAST				2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR DEATH ESTI- MATED <input checked="" type="checkbox"/> 11/24/83		2b. HOUR 10 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11/26/83 19 1:50 P.M.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1544-B Old Towne Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman				12b. KIND OF BUSINESS OR INDUSTRY B & O R.R. 21502		
13a. STATE Md. - 21502		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1544-B Old Towne Manor				
14. FATHER'S NAME Charles		MIDDLE ---		LAST Willingham		15. MOTHER'S MAIDEN NAME FIRST Eva		MIDDLE ---		LAST Trail		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) (W.W.I)		16b. SOCIAL SECURITY NO. 705-12-6956		17. INFORMANT Robert Willingham -Stafford, Virginia		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Giovanni Mastrangelo, M.D. DEPUTY MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo		ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/29/83		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION CITY OR TOWN Cumberland-Allegany Co.-Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME George Upchurch Funeral Home, P.A.		ADDRESS 202 Greene Street-Cumberland, Maryland 21502		25a. DATE REC'D. BY REGISTRAR DEC 09 1983		25b. REGISTRAR'S SIGNATURE John J. Cawley						
BP _____		DHMH-17 (VR A15 ME (5))		15M 2/80								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or [Item 18 shows any injury, or other traumatic event, the medical certification must be notified at once.]

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 28520			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
<i>Francis</i>			<i>W</i>	<i>Zahradka</i>		<i>11 5 83</i>						<i>1300 PM</i>			
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White	MONTH DAY YEAR			85			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Germany			USA						<i>Allegany</i>			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<i>Cumberland</i>			<i>ALLEGANY COUNTY Nursing Home</i>									<i>Retired Boilermaker-Railroad</i>		<i>21508</i>	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Allegany		Cumberland					<i>47 East Elder St.</i>					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
			<i>Francis</i>	<i>Zahradka</i>					<i>Mary Newberg</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			<i>705-12-0875</i>			<i>Mrs. Mary Burgess, Cumberland, Daughter</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause lost (b) <i>Coronary Artery Disease</i>															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Diabetes Mellitus</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													22c. DATE SIGNED <i>11/5/83</i>		
22b. SIGNATURE <i>N.A. Rajithan MD</i>			22d. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>N.A. Rajithan MD</i>			22f. ADDRESS <i>Memorial Med Bldg</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>11-8-1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Marys Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Cumberland, Allegany Md.</i>			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>James F. Scarpelli, Cumberland Md.</i>			ADDRESS <i>21 Nov 14 1983</i>			25a. DATE REC'D. BY REGISTRAR <i>John J. Casper</i>			25b. REGISTRAR						



Black Smith 89 + 1.40